Clinical Policy: Temsirolimus (Torisel)

Reference Number: ERX.SPA.285
Effective Date: 12.01.18
Last Review Date: 11.21
Line of Business: Commercial, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Temsirolimus for injection (Torisel®) is a kinase inhibitor.

FDA Approved Indication(s)
Torisel is indicated for the treatment of advanced renal cell carcinoma (RCC).

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Torisel is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Renal Cell Carcinoma (must meet all)**:**

1. Diagnosis of advanced RCC (i.e., relapsed, metastatic, or stage IV disease);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Use is as a single agent;
5. Member has at least 3 prognostic risk factors (see *Appendix D*);
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 25 mg per week (*50 mg per week if member is on a concomitant strong CYP3A4 inducer such as dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifampicin, phenobarbital*);
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration: 6 months

B. Endometrial Carcinoma (off-label) (must meet all)**:**

1. Diagnosis of endometrial carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Use is as a single agent;
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 25 mg per week (*50 mg per week if member is on a concomitant strong CYP3A4 inducer such as dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifampicin, phenobarbital*);
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration: 6 months

C. Soft Tissue Sarcoma (off-label) (must meet all)**:**
1. Diagnosis of perivascular epitheliod cell tumor (PEComa), recurrent angiomyolipoma, or lymphangioleiomyomatosis;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Use is as a single agent;
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 25 mg per week (*50 mg per week if member is on concomitant strong CYP3A4 inducer such as dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifampicin, phenobarbital*);
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration: 6 months

D. Other diagnoses/indications
1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions, or documentation supports that member is currently receiving Torisel for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 25 mg per week (*50 mg per week if member is on a concomitant strong CYP3A4 inducer such as dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifampicin, phenobarbital*);
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off-label use policy – ERX.PA.01 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
NCCN: National Comprehensive Cancer Network
PEComas: perivascular epithelioid cell tumors
RCC: renal cell carcinoma

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): bilirubin > 1.5 times the upper limit of normal
- Boxed warning(s): none reported

Appendix D: General Information
- At least 3 of the following 6 prognostic risk factors (based on the Torisel pivotal trial):
  - Interval of less than 1 year from time of RCC diagnosis to start of systemic therapy
  - Karnofsky performance status score of 60 or 70
  - Hemoglobin level below normal (e.g., men < 13.5 g/dL, women < 12 g/dL)
  - Corrected serum calcium level > 10 mg/dL (2.5 mmol/L)
  - Serum lactate dehydrogenase level > 1.5 times the upper limit of normal
  - More than one metastatic organ site

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
RCC	25 mg administered as an IV infusion over a 30-60 minute period once a week Consider 50 mg once a week if concomitant strong CYP3A4 inducer (e.g., dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifampicin, phenobarbital)	50 mg/week

VI. Product Availability
Kit: single-use vial 25 mg/mL temsirolimus; diluent vial 1.8 mL

VII. References
1. Torisel Prescribing Information. Philadelphia, PA: Pfizer, Inc.; March 2018. Available at http://labeling.pfizer.com/showlabeling.aspx?id=490. Accessed June 30, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed June 30, 2021.
3. National Comprehensive Cancer Network. Kidney Cancer Version 4.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf. Accessed June 30, 2021.
4. National Comprehensive Cancer Network. Soft Tissue Sarcoma Version 2.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/sarcoma.pdf . Accessed June 30, 2021.
5. National Comprehensive Cancer Network. Uterine Neoplasms Version 3.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/uterine.pdf, Accessed June 30, 2021.
6. Hudes G, Carducci M, Tomczak P, et al. Temsirolimus, interferon alfa, or both for advanced renal-cell carcinoma. N Eng J Med 2007; 356:2271-2281.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	08.07.18	11.18
4Q 2019 annual review: RCC – added requirements for use as a single agent and at least 3 prognostic risk factors; references reviewed and updated.	09.10.19	11.19
4Q 2020 annual review: no significant changes; references reviewed and updated.	08.10.20	11.20
4Q 2021 annual review: no significant changes; references reviewed and updated.	06.30.21	11.21

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of

medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members.