

## Clinical Policy: Duvelisib (Copiktra)

Reference Number: ERX.SPA.287

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

Duvelisib (Copiktra<sup>®</sup>) is a kinase inhibitor.

### FDA Approved Indication(s)

Copiktra is indicated for:

- Treatment of adult patients with relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) after at least two prior therapies
- Treatment of adult patients with relapsed or refractory follicular lymphoma (FL)\* after at least two prior systemic therapies

*\*This indication is approved under accelerated approval based on overall response rate (ORR); continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.*

### 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<sup>™</sup> that Copiktra is **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (must meet all):

1. Diagnosis of CLL or SLL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age  $\geq$  18 years;
4. Relapsed/refractory disease after at least one prior therapy (*see Appendix B for examples*);\*  
*\*Prior authorization may be required.*
5. Prescribed as a single agent;
6. Request meets one of the following (a or b):\*
  - a. Dose does not exceed 50 mg (2 capsules) per day;
  - 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:

**Commercial** – Length of Benefit

**Medicaid** – 6 months

##### B. Follicular and Marginal Zone Lymphomas (must meet all):

1. Diagnosis of one of the following (a or b):
  - a. FL;
  - b. Marginal zone lymphoma (off-label) (i, ii, or iii):
    - i. Splenic marginal zone lymphoma;
    - ii. Nodal marginal zone lymphoma;
    - iii. Extranodal marginal zone lymphoma (a or b):
      - a) Gastric MALT lymphoma;

- b) Nongastric MALT lymphoma;
- 2. Prescribed by or in consultation with an oncologist or hematologist;
- 3. Age ≥ 18 years;
- 4. Relapsed/refractory disease after ≥ 2 prior therapies (*see Appendix B for examples*);\*  
*\*Prior authorization may be required.*
- 5. Request meets one of the following (a or b):\*
  - a. Dose does not exceed 50 mg (2 capsules) per day;
  - 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:**

**Commercial** – Length of Benefit

**Medicaid** – 6 months

**C. 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 Copiktra 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 50 mg (2 capsules) per day;
  - 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.*

**Commercial** – Length of Benefit

**Medicaid** – 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*

CLL: chronic lymphocytic leukemia

FDA: Food and Drug Administration

FL: follicular lymphoma

NCCN: National Comprehensive Cancer Network

SLL: small lymphocytic lymphoma

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.*

| <b>Drug Name</b>   | <b>Dosing Regimen</b> | <b>Dose Limit/ Maximum Dose</b> |
|--|-----------------------|---------------------------------|
| <b>CLL/SLL</b><br><u>Examples of first-line, second-line and subsequent therapies:</u> <ul style="list-style-type: none"> <li>• FCR (fludarabine, cyclophosphamide, rituximab)</li> <li>• HDMP (high-dose methylprednisolone) + rituximab</li> <li>• <u>Single-agent examples:</u> Imbruvica® (ibrutinib); Venclexta® (venetoclax) ± Gazyva® (obinutuzumab) or rituximab; Campath® (alemtuzumab) ± rituximab; Gazyva; Copiktra® (duvelisib); Calquence® (acalabrutinib); Revlimid® (lenalidomide) ± rituximab; Arzerra® (ofatumumab) ± FC (fludarabine, cyclophosphamide); Leukeran® (chlorambucil) + rituximab</li> </ul> | Varies                | Varies                          |
| <b>Follicular Lymphoma</b><br><u>Examples of first-line, second-line and subsequent therapies:</u> <ul style="list-style-type: none"> <li>• bendamustine + Gazyva or rituximab</li> <li>• CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) + Gazyva or rituximab</li> <li>• CVP (cyclophosphamide, vincristine, prednisone) + Gazyva or rituximab</li> <li>• <u>Single-agent examples:</u> rituximab; Revlimid ± rituximab</li> </ul>   | Varies                | Varies                          |
| <b>Marginal Zone Lymphomas</b><br><u>Examples of first-line, second-line and subsequent therapies:</u> <ul style="list-style-type: none"> <li>• bendamustine + rituximab</li> <li>• RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone)</li> <li>• RCVP (rituximab, cyclophosphamide, vincristine, prednisone)</li> <li>• <u>Single-agent examples:</u> rituximab; Leukeran ± rituximab; cyclophosphamide ± rituximab; Imbruvica; Revlimid ± rituximab; Copiktra; Aliqopa® (copanlisib)</li> </ul>   | Varies                | Varies                          |

*Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.*

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): none reported
- Boxed warning(s): fatal and serious toxicities: infections, diarrhea or colitis, cutaneous reactions, and pneumonitis

**V. Dosage and Administration**

| <b>Indication</b> | <b>Dosing Regimen</b>   | <b>Maximum Dose</b> |
|-------------------|---|---------------------|
| CLL/SLL, FL       | 25 mg PO BID with or without food. A cycle consists of 28 days. | 50 mg/day           |

**VI. Product Availability**

Capsules: 25 mg, 15 mg

**VII. References**

1. Copiktra Prescribing Information. Needham, MA: Verastem, Inc.; July 2019. Available at <https://www.copiktra.com>. Accessed July 27, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: [www.nccn.org](http://www.nccn.org). Accessed June 28, 2021.

3. National Comprehensive Cancer Network. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma Version 4.2021. Available at [www.nccn.org](http://www.nccn.org). Accessed July 13, 2021.
4. National Comprehensive Cancer Network. B-Cell Lymphomas Version 4.2021. Available at [www.nccn.org](http://www.nccn.org). Accessed July 13, 2021.

| Reviews, Revisions, and Approvals   | Date     | P&T Approval Date |
|---|----------|-------------------|
| Policy created.   | 10.16.18 | 11.18             |
| 4Q 2019 annual review: FDA/NCCN dosing limitation added; marginal zone lymphomas added per NCCN; added Medicaid line of business with 6 month approval durations; references reviewed and updated.                | 08.27.19 | 11.19             |
| 4Q 2020 annual review: no significant changes; references reviewed and updated.   | 08.11.20 | 11.20             |
| 4Q 2021 annual review: for CLL/SLL, added requirement for use as a single agent; modified Medicaid continued approval duration from 6 months to 12 months per standard approach; references reviewed and updated. | 06.28.21 | 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.

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