Clinical Policy: Avapritinib (Ayvakit)

Reference Number: ERX.SPA.372
Effective Date: 03.01.20
Last Review Date: 08.21
Line of Business: Commercial, Medicaid

Revision Log

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

Description
Avapritinib (Ayvakit™) is a tyrosine kinase inhibitor.

FDA Approved Indication(s)
Ayvakit is indicated for the treatment of adults with:

- Unresectable or metastatic gastrointestinal stromal tumor (GIST) harboring a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations
- Advanced systemic mastocytosis (AdvSM), including aggressive systemic mastocytosis (ASM), systemic mastocytosis with an associated hematological neoplasm (SM-AHN), and mast cell leukemia (MCL)

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 Ayvakit is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Gastrointestinal Stromal Tumor (must meet all)**:**

1. Diagnosis of unresectable or metastatic GIST;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For brand Ayvakit request, member must use generic avapritinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. One of the following (a or b):
   a. Documentation of a PDGFRA exon 18 D842V mutation;
   b. Member meets both of the following (i and ii):
      i. Documentation of a PDGFRA exon 18 mutation other than D842V;
      ii. Failure of imatinib, unless contraindicated or clinically significant adverse effects are experienced;
      **Prior authorization may be required for imatinib*
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 300 mg (1 tablet) 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:
Medicaid – 6 months
Commercial – Length of Benefit

B. Advanced Systemic Mastocytosis (must meet all)**:**
1. Diagnosis of one of the following (a, b, or c):
   a. ASM;
   b. ASM-AHN;
   c. MCL;
2. Prescribed by or in consultation with an oncologist, allergist, or immunologist;
3. Age ≥ 18 years;
4. For brand Ayvakit request, member must use generic avapritinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. Request meets one of the following (a or b):
   a. Dose does not exceed 200 mg (1 tablet) 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:
Medicaid – 6 months
Commercial – Length of Benefit

C. Myeloid/Lymphoid Neoplasm with Eosinophilia and Tyrosine Kinase Fusion Gene (must meet all)**:**
1. Diagnosis of myeloid/lymphoid neoplasm with eosinophilia (MLNE) and FIP1L1-PDGFRA rearrangement;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For brand Ayvakit request, member must use generic avapritinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. Member meets both of the following (i and ii):
   a. Documentation of a PDGFRA D842V mutation;
   b. Failure of imatinib*, unless contraindicated or clinically significant adverse effects are experienced;

   **Prior authorization may be required for imatinib*
6. Dose is within FDA maximum limit for any FDA-approved indication or 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:
Medicaid – 6 months
Commercial – Length of Benefit

1. 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 Ayvakit for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For brand Ayvakit request, member must use generic avapritinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed any of the following (i or ii):
      i. GIST: 300 mg (1 tablet) per day;
      ii. AdvSM: 200 mg (1 tablet) 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.*

Approval duration:
Medicaid – 12 months
Commercial – Length of Benefit

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

AdvSM: advanced systemic mastocytosis
ASM: aggressive systemic mastocytosis
FDA: Food and Drug Administration
GIST: gastrointestinal stromal tumor
MCL: mast cell leukemia
MLNE: myeloid/lymphoid neoplasm with eosinophilia
NCCN: National Comprehensive Cancer Network
PDGFR: platelet-derived growth factor receptor
SM-AHN: systemic mastocytosis with associated hematological neoplasm

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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
imatinib mesylate (Gleevec®)	**GIST** 400 mg PO QD up to 400 mg BID [FDA label] **MLNE** 100-400 mg PO QD [NCCN]	800 mg/day

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
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
GIST	300 mg PO QD	300 mg/day
AdvSM, including ASM, MCL, SM-AHN	200 mg PO QD	200 mg/day

VI. Product Availability

Tablets: 25 mg, 50 mg, 100 mg, 200 mg, 300 mg

VII. References

1. Ayvakit Prescribing Information. Cambridge, MA: Blueprint Medicines Corporation; June 2021. Available at: www.ayvakit.com. Accessed July 1, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed July 1, 2021.
3. National Comprehensive Cancer Network. Gastrointestinal Stromal Tumors (GISTs) Version 1.2021. Available at: www.nccn.org. Accessed November 5, 2020.
4. National Comprehensive Cancer Network. Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes Version 3.2021. Available at: www.nccn.org. Accessed November 5, 2020.
5. National Comprehensive Cancer Network. Systemic Mastocytosis Version 2.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/mastocytosis.pdf. Accessed July 1, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01.21.20	02.20
1Q 2021 annual review: oral oncology generic redirection language added; NCCN recommended use for myeloid/lymphoid neoplasm added; references reviewed and updated.	11.05.20	02.21
RT4: added criteria for newly approved indication of advanced systemic mastocytosis.	07.01.21	08.21

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.