Clinical Policy: Selpercatinib (Retevmo)

Reference Number: ERX.SPA.388
Effective Date: 05.08.20
Last Review Date: 05.22
Line of Business: Commercial, Medicaid

Revision Log

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

Description
Selpercatinib (Retevmo™) is a kinase inhibitor.

FDA Approved Indication(s)
Retevmo is indicated for the treatment of:

- Adult patients with metastatic *RET* fusion-positive non-small cell lung cancer (NSCLC)*
- *RET*-mutant medullary thyroid cancer (MTC)*
  - Adult and pediatric patients 12 years of age and older with advanced or metastatic *RET*-mutant MTC who require systemic therapy
- *RET* fusion-positive thyroid cancer*
  - Adult and pediatric patients 12 years of age and older with advanced or metastatic *RET* fusion-positive thyroid cancer who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate)*

**This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).*

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

I. Initial Approval Criteria

A. Non-Small Cell Lung Cancer (must meet all)**:**

1. Diagnosis of recurrent, advanced, or metastatic NSCLC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Documentation of *RET* fusion-positive disease (e.g., KIF5B-RET);
5. Retevmo is not prescribed concurrently with Gavreto™;
6. Member has not received prior *RET* targeted therapy (e.g., Gavreto);
7. Prescribed as a single agent;
8. Request meets one of the following (a, b, or c):*
   a. Weight < 50 kg: Dose does not exceed 120 mg (2 capsules) twice daily;
   b. Weight ≥ 50 kg: Dose does not exceed 160 mg (2 capsules) twice daily;
   c. 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. Thyroid Cancer (must meet all)**:**
1. Diagnosis of one of the following (a, b, or c):
   a. MTC;
   b. Differentiated thyroid carcinoma (DTC; Hurthle cell, papillary, follicular);
   c. Anaplastic thyroid carcinoma (ATC);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 12 years;
4. Disease is recurrent, advanced, or metastatic;
5. For MTC, documentation of *RET* mutant-positive disease (e.g., RET M918T);
6. For DTC or ATC, documentation of *RET* fusion-positive disease (e.g., CCDC6-RET, KIF5B-RET), and member is radioactive iodine-refractory (if radioactive iodine is appropriate);
7. For DTC, disease is not amenable to radioactive iodine therapy;
8. Retevmo is not prescribed concurrently with Gavreto;
9. Member has not received prior *RET* targeted therapy (e.g., Gavreto);
10. Prescribed as a single agent;
11. Request meets one of the following (a, b, or c):*
    a. Weight < 50 kg: Dose does not exceed 120 mg (2 capsules) twice daily;
    b. Weight ≥ 50 kg: Dose does not exceed 160 mg (2 capsules) twice daily;
    c. 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. Histiocytic Neoplasms (off-label) (must meet all):
1. Diagnosis of one of the following histiocytic neoplasms (a, b, or c):
   a. Erdheim-Chester disease;
   b. Langerhans cell histiocytosis;
   c. Rosai-Dorfman disease;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Documentation of *RET* fusion-positive disease;
4. Retevmo is not prescribed concurrently with Gavreto;
5. Member has not received prior *RET* targeted therapy (e.g., Gavreto);
6. Prescribed as a single agent;
7. Request meets one of the following (a, b, or c):*
   a. Weight < 50 kg: Dose does not exceed 120 mg (2 capsules) twice daily;
   b. Weight ≥ 50 kg: Dose does not exceed 160 mg (2 capsules) twice daily;
   c. 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

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 Retevmo for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;

3. Retevmo is not prescribed concurrently with Gavreto;
4. Member has not received prior *RET* targeted therapy (e.g., Gavreto);
5. If request is for a dose increase, request meets one of the following (a, b, or c):*
   a. Weight < 50 kg: New dose does not exceed 120 mg (2 capsules) twice daily;
   b. Weight ≥ 50 kg: New dose does not exceed 160 mg (2 capsules) twice daily;
   c. 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:
Commercial – Length of Benefit
Medicaid – 12 months

B. Other diagnoses/indications

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

ATC: Anaplastic thyroid carcinoma
DTC: differentiated thyroid carcinoma
FDA: Food and Drug Administration
MTC: medullary thyroid cancer
NCCN: National Comprehensive Cancer Network
NSCLC: non-small cell lung cancer

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
NSCLC, thyroid cancer	Weight < 50 kg: 120 mg PO BID Weight ≥ 50 kg: 160 mg PO BID	Weight < 50 kg: 240 mg/day Weight ≥ 50 kg: 320 mg/day

VI. Product Availability

Capsules: 40 mg, 80 mg

VII. References

1. Retevmo Prescribing Information. Indianapolis, IN: Lilly USA, LLC; January 2021. Available at: http://pi.lilly.com/us/retevmo-uspi.pdf. Accessed February 15, 2022.
2. Selpercatinib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: https://www.nccn.org/professionals/drug_compendium. Accessed February 15, 2022.
3. National Comprehensive Cancer Network. Histiocytic Neoplasms Version 2.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/histiocytic_neoplasms.pdf. Accessed February 15, 2022.
4. National Comprehensive Cancer Network. Thyroid Carcinoma Version 3.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf. Accessed February 15, 2022.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	03.10.20	05.20
Drug is now FDA approved - criteria updated per FDA labeling: For NSCLC, failure of platinum-based chemotherapy and PD-1/PD-L1 therapy removed per FDA; recurrent, advanced or metastatic replaces advanced per FDA and NCCN; dosing added; for thyroid cancer, MTC restricted to mutant-positive rather than also fusion-positive; failure of systemic therapy removed per FDA; dosing added; references reviewed and updated.	06.02.20	08.20
Updated criteria to prevent concurrent use of Gavreto as well as prevent history of RET targeted therapy.	09.23.20	11.20
2Q 2021 annual review: no significant changes; references reviewed and updated.	01.26.21	05.21
2Q 2022 annual review: per NCCN added the following: added criterion for use as single-agent therapy for NSCLC and thyroid cancers, added qualifier of recurrent thyroid cancer, removed radioactive iodine criteria for ATC, revised DTC/MTC-specific criteria to align with Gavreto, and added indication criteria for histiocytic neoplasms; references reviewed and updated.	02.15.22	05.22

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.