Clinical Policy: Pralsetinib (Gavreto)

Reference Number: ERX.SPA.414
Effective Date: 12.01.20
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
Pralsetinib (Gavreto™) is an oral tyrosine kinase inhibitor of wild-type rearranged during transfection (RET) and oncogenic *RET* fusions (CCDC6-RET) and mutations (RET V804L, RET V804M, and RET M918T).

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

- Adult patients with metastatic *RET* fusion-positive non-small cell lung cancer (NSCLC) as detected by an FDA approved test.*
- Adult and pediatric patients 12 years of age and older with advanced or metastatic *RET*-mutant medullary thyroid cancer (MTC) who require systemic therapy.*
- 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.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Gavreto 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., CCDC6-RET, KIF5B-RET);
5. Gavreto is not prescribed concurrently with Retevmo™;
6. Member has not received prior *RET* targeted therapy (e.g., Retevmo);
7. Prescribed as a single agent;
8. Request meets one of the following (a, b, or c):*
   a. Dose does not exceed 400 mg (4 capsules) daily;
   b. Dose does not exceed 800 mg (8 capsules) daily and prescriber attestation of member's inability to avoid concomitant use of CYP3A inducer (e.g., carbamazepine, rifampin, ritonavir, St. John's wort);
   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. Gavreto is not prescribed concurrently with Retevmo;
9. Member has not received prior *RET* targeted therapy (e.g., Retevmo);
10. Request meets one of the following (a, b, or c):*
    a. Dose does not exceed 400 mg (4 capsules) daily;
    b. Dose does not exceed 800 mg (8 capsules) daily and prescriber attestation of member's inability to avoid concomitant use of CYP3A inducer (e.g., carbamazepine, rifampin, ritonavir, St. John's wort);
    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. 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 Gavreto for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. Gavreto is not prescribed concurrently with Retevmo;
4. Member has not received prior *RET* targeted therapy (e.g., Retevmo);
5. If request is for a dose increase, request meets one of the following (a, b, or c):*
   a. New dose does not exceed 400 mg (4 capsules) daily;
   b. New dose does not exceed 800 mg (8 capsules) daily and prescriber attestation of member's inability to avoid concomitant use of CYP3A inducer (e.g., carbamazepine, rifampin, ritonavir, St. John's wort);
   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 (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

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
RET: rearranged during transfection

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	400 mg PO QD	800 mg/day with coadministration of strong CYP3A inducers

VI. Product Availability

Capsule: 100 mg

VII. References

1. Gavreto Prescribing Information. Cambridge, MA: Blueprint Medicines Corporation; February 2022. Available at: https://www.blueprintmedicines.com/uspi/GAVRETO.pdf. Accessed February 9, 2022.
2. Pralsetinib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed February 9, 2022.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	10.13.20	11.20
RT4: Criteria added for new FDA indications related to thyroid cancer.	12.10.20	
2Q 2021 annual review: no significant changes; references reviewed and updated.	01.26.21	05.21
2Q 2022 annual review: added criterion for use as single-agent therapy for NSCLC; added qualifier of recurrent thyroid cancer and added criterion for DTC that disease is not amenable to radioactive iodine therapy per NCCN; references reviewed and updated.	02.09.22	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.