Clinical Policy: Nintedanib (Ofev)

Reference Number: ERX.SPA.172
Effective Date: 01.11.17
Last Review Date: 08.20
Line of Business: Commercial, Medicaid

Revision Log

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

Description
Nintedanib (Ofev®) is a kinase inhibitor.

FDA Approved Indication(s)
Ofev is indicated:
- For the treatment of idiopathic pulmonary fibrosis (IPF);
- For the treatment of chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype;
- To slow the rate of decline in pulmonary function in patients with systemic sclerosis associated interstitial lung disease (SSc-ILD).

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

I. Initial Approval Criteria

A. Idiopathic Pulmonary Fibrosis (must meet all)**:**
1. Diagnosis of IPF;
2. Prescribed by or in consultation with a pulmonologist;
3. Age ≥ 18 years;
4. Member meets (a and b):
   a. Pulmonary fibrosis on high resolution computed tomography (HRCT);
   b. Known causes of pulmonary fibrosis have been ruled out *(see Appendix D);*
5. Dose does not exceed 300 mg (2 capsules) per day.

Approval duration: 6 months

B. Chronic Fibrosing Interstitial Lung Disease (must meet all)**:**
1. Diagnosis of one of the following chronic fibrosing ILD subtypes (a-g):
   a. Chronic fibrosing hypersensitivity pneumonitis;
   b. Autoimmune ILD (e.g., rheumatoid arthritis-related ILD);
   c. Mixed connective tissue disease-associated ILD;
   d. Idiopathic non-specific interstitial pneumonia;
   e. Unclassifiable idiopathic interstitial pneumonia;
   f. Environmental/occupational exposure-related ILD;
   g. Sarcoidosis;
2. Prescribed by or in consultation with a pulmonologist;
3. Age ≥ 18 years;
4. For new starts only: member meets both of the following within the past 24 months (a and b):
   a. Pulmonary fibrosis affecting > 10% of lung volume on HRCT;
   b. Documentation of one of the following (i or ii):
      i. A relative decline in the forced vital capacity (FVC) of ≥ 10% of the predicted value;

ii. A relative decline in the FVC of 5% to < 10% of the predicted value plus either worsening of respiratory symptoms or an increased extent of fibrosis on HRCT;

5. Dose does not exceed 300 mg (2 capsules) per day.

Approval duration: 6 months

C. Systemic Sclerosis Associated Interstitial Lung Disease (must meet all)**:**

1. Diagnosis of SSc-ILD;
2. Prescribed by or in consultation with a pulmonologist;
3. Age ≥ 18 years;
4. Member meets (a and b):
   a. Pulmonary fibrosis on HRCT;
   b. Additional signs of SSc are identified *(see Appendix E);*
5. Dose does not exceed 300 mg (2 capsules) per day.

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 member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 300 mg (2 capsules) per day.

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

ACR: American College of Rheumatology
ATS: American Thoracic Society
CTD: connective tissue disease
FDA: Food and Drug Administration
FVC: forced vital capacity
IPF: idiopathic pulmonary fibrosis
ILD: interstitial lung disease
NCCN: National Comprehensive Cancer Network
NSCLC: non-small cell lung cancer
SSc-ILD: systemic sclerosis associated interstitial lung disease

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: American Thoracic Society (ATS) 2018 IPF Guidelines
ATS diagnostic criteria for IPF are built around pulmonary fibrosis findings on HRCT and exclusion of known causes of ILD (e.g., domestic and occupational environmental exposures, CTD, drug toxicity).

Appendix E: American College of Rheumatology (ACR) 2013 SSc Classification Criteria
While the majority of patients with SSc experience skin thickening and variable involvement of internal organs, there is no one confirmatory test for SSc. Similar to the IPF guidelines above, ACR lists HRCT as a diagnostic method for determining pulmonary fibrosis in SSc-ILD. The other diagnostic parameters below are drawn from ACR's scoring system purposed for clinical trials. While informative, ACR cautions that the scoring system parameters are not all inclusive of the myriad of SSc manifestations that may occur across musculoskeletal, cardiovascular, renal, neuromuscular and genitourinary systems.
Examples of SSc skin/internal organ manifestations and associated laboratory tests:

- Skin thickening of the fingers
- Fingertip lesions
- Telangiectasia
- Abnormal nailfold capillaries
- Raynaud's phenomenon
- SSc-ILD
- Pulmonary arterial hypertension
- SSc-related autoantibodies
  - Anticentromere
  - Anti–topoisomerase I [anti–Scl-70]
  - Anti–RNA polymerase III

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
IPF, SSc-ILD, chronic fibrosing ILD with a progressive phenotype	150 mg PO BID approximately 12 hours apart (100 mg BID for patients with mild hepatic impairment or management of adverse reactions)	300 mg/day

VI. Product Availability

Capsules: 100 mg, 150 mg

VII. References

1. Ofev Prescribing Information. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc.; March 2020. Available at: https://docs.boehringer-ingelheim.com/Prescribing%20Information/PIs/Ofev/ofev.pdf. Accessed April 6, 2020.
2. Raghu G, Remy-Jardin M, Myers JL. Diagnosis of idiopathic pulmonary fibrosis. An official ATS/ERS/JRS/ALAT clinical practice guideline. American Thoracic Society. Am J Respir Crit Care Med. Stepember 1, 2018; 198(5):e44-e68.
3. van den Hoogen F, Khanna D, Fransen J, et al. 2013 classification criteria for systemic sclerosis: an American College of Rheumatology/European League against Rheumatism Collaborative Initiative. Ann Rheum Dis. 2013; 72:1747-1755.
4. Flaherty KR, Wells AU, Cottin V, et al. Nintedanib in progressive fibrosing interstitial lung diseases. N Engl J Med 2019;381:1718-27.
5. Richeldi L, Varone F, Bergna M, et al. Pharmacological management of progressive-fibrosing interstitial lung diseases: a review of the current evidence. Eur Respir Rev 2018;27:180074.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	11.16	12.16
4Q17 Annual Review Converted to new template.	09.27.17	11.17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added age restriction as safety and efficacy have not been established in pediatric patients per PI.		
3Q 2018 annual review: removed requirement for high-resolution computed tomography or surgical lung biopsy findings confirming diagnosis; references reviewed and updated.	05.10.18	08.18
3Q 2019 annual review: no significant changes; references reviewed and updated.	05.21.19	08.19
Criteria added for new FDA indication: SSc-ILD; diagnostic criteria added for IPF; references reviewed and updated.	10.22.19	02.20
3Q 2020 annual review: criteria added for new FDA indication: chronic fibrosing ILD with a progressive phenotype; references reviewed and updated.	04.21.20	08.20

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.