Clinical Policy: Trabectedin (Yondelis)
Reference Number: ERX.SPA.304
Effective Date: 03.01.19
Last Review Date: 02.19

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

Description
Trabectedin (Yondelis®) is an alkylating drug.

FDA Approved Indication(s)
Yondelis is indicated for the treatment of patients with unresectable or metastatic liposarcoma (LPS) or leiomyosarcoma (LMS) who received a prior anthracycline-containing regimen.

Policy/Criteria
Provider must submit documentation (including 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 Yondelis is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Soft Tissue Sarcoma (must meet all):
      1. Diagnosis of unresectable or metastatic soft tissue sarcoma (STS);
      2. Prescribed by or in consultation with an oncologist;
      3. Age ≥ 18 years;
      4. If uterine leiomyosarcoma (uLMS), member has received a prior anthracycline-containing regimen (e.g., doxorubicin);
      5. Request meets one of the following (a or b):
         a. Dose does not exceed 1.5 mg/m² body surface area every 3 weeks;
         b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).
   
   Approval duration: 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. Soft Tissue Sarcoma (must meet all):
      1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions, or documentation supports that member is currently receiving Yondelis 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 1.5 mg/m² body surface area every 3 weeks;
         b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).
   
   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
FDA: Food and Drug Administration
LMS: leiomyosarcoma
LPS: liposarcoma
STS: soft tissue sarcoma
uLMS: uterine leiomyosarcoma

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 for all relevant lines of business and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>uLMS - examples of anthracycline-containing regimens: doxorubicin ± gemcitabine, olaratumab, fosfamide, or dacarbazine; epirubicin; liposomal doxorubicin</td>
<td>Varies</td>
<td>Varies</td>
</tr>
</tbody>
</table>

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): known hypersensitivity to trabectedin
- Boxed warning(s): none reported

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>LPS, LMS</td>
<td>1.5 mg/m² (body surface area) as a 24-hour IV infusion every 21 days (3 weeks), until disease progression or unacceptable toxicity.</td>
<td>Varies</td>
</tr>
</tbody>
</table>

VI. Product Availability
Single-dose vial with powder for injection: 1 mg

VII. References
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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