Clinical Policy: Afatinib (Gilotrif)

Reference Number: ERX.SPA.02
Effective Date: 04.01.17
Last Review Date: 05.20
Line of Business: Commercial, Medicaid

Revision Log

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

Description
Afatinib (Gilotrif®) is a kinase inhibitor.

FDA Approved Indication(s)
Gilotrif is indicated for:

- First-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test.
- Treatment of patients with metastatic squamous NSCLC progressing after platinum-based chemotherapy.

Limitation(s) of use: The safety and efficacy of Gilotrif have not been established in patients whose tumors have resistant EGFR mutations.

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 Gilotrif 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. Member meets one of the following (a or b):
   a. Disease is positive for a sensitizing EGFR mutation (e.g., exon 19 deletion or insertion; exon 21 point mutation - L858R, L861Q; exon 18 point mutation - G719X; exon 20 point mutation - S768I);
   b. Squamous cell carcinoma histology with progression after platinum-based chemotherapy (e.g., cisplatin, carboplatin);
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 40 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. 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. Non-Small Cell Lung Cancer (must meet all)**:**
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions, or documentation supports that member is currently receiving Gilotrif 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 40 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

EGFR: epidermal growth factor receptor
FDA: Food and Drug Administration
NCCN: National Comprehensive Cancer Network
NSCLC: non-small cell lung cancer

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
Platinum-based chemotherapy (e.g., cisplatin, carboplatin)	Varies	Varies

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
NSCLC	40 mg PO QD	40 mg/day

VI. Product Availability

Tablets: 20 mg, 30 mg, 40 mg

VII. References

1. Gilotrif Prescribing Information. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc.; October 2019. Available at: http://gilotrif.com. Accessed February 6, 2020.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed February 6, 2020.
3. National Comprehensive Cancer Network Guidelines. Non-Small Cell Lung Cancer (Version 2.2020). Available at www.nccn.org. Accessed February 6, 2020.
4. National Comprehensive Cancer Network Guidelines. Central Nervous System Cancers Version 3.2019. Available at www.nccn.org. Accessed February 6, 2020.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01.17	02.17
1Q18 annual review: Initial: Added age requirement as safety and efficacy have not been established in pediatric patients. Added prescriber requirement. Modified approval duration from Length of Benefit to 6 months. Re-auth: Added COC for NSCLC. Modified approval duration from Length of Benefit to 12 months. Both: Modified max dosing criteria to allow for off-label dosing.	10.30.17	02.18
New indication: updated FDA approved indication and approval criteria to allow coverage for the following uncommon EGFR mutations: L861Q, G719X, and S768I for metastatic NSCLC with sensitizing EGFR mutation; approval duration for both initial and continued therapy changed to length of benefit; added NCCN 2A recommended off-label use for central nervous system cancer with brain metastases; references reviewed and updated.	02.13.18	05.18
2Q 2019 annual review: no significant changes; NCCN designation of advanced added to NSCLC; EGFR mutations restated as examples; NSCLC CNS metastasis moved from off-label section and incorporated into NSCLC criteria set; references reviewed and updated.	02.19.19	05.19
2Q 2020 annual review: no significant changes; added Medicaid line of business with 6/12 month initial/continued authorization duration; references reviewed and updated.	02.06.20	05.20

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.