Clinical Policy: Ibrutinib (Imbruvica)

Reference Number: HIM.PA.SP48
Effective Date: 01.01.18
Last Review Date:
Line of Business: Health Insurance Marketplace

Revision Log

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

Description

Ibrutinib (Imbruvica®) is a kinase inhibitor.

FDA Approved Indication(s)

Imbruvica is indicated:

- For the treatment of adult patients with mantle cell lymphoma (MCL) who have received at least one prior therapy
  - Accelerated approval was granted for this indication based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial
- For the treatment of adult patients with chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
- For the treatment of adult patients with chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) with 17p deletion
- For the treatment of adult patients with Waldenström's macroglobulinemia (WM)
- For the treatment of adult patients with marginal zone lymphoma (MZL) who require systemic therapy and have received at least one prior anti-CD20-based therapy
  - Accelerated approval was granted for this indication based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial
- For the treatment of adult patients with chronic graft-versus-host disease (cGVHD) after failure of one or more lines of systemic therapy

Policy/Criteria

Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

I. Initial Approval Criteria

A. Mantle Cell Lymphoma (must meet all)**:**

1. Diagnosis of MCL;
2. Age ≥ 18 years;
3. Member meets one of the following (a or b):
   a. FDA approved use: previously received at least one prior therapy for MCL;
   b. Off-label NCCN recommended use: Ibrutinib will be used in combination with rituximab as pre-treatment in order to limit the number of cycles of less

aggressive induction therapy with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen;
4. Dose does not exceed 560 mg per day (4 capsules per day).

Approval duration: 6 months

B. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (must meet all)**:**
1. Diagnosis of CLL/SLL;
2. Age ≥ 18 years;
3. Dose does not exceed 420 mg per day (3 capsules per day).

Approval duration: 6 months

C. Waldenström's Macroglobulinemia (must meet all)**:**
1. Diagnosis of WM;
2. Age ≥ 18 years;
3. Dose does not exceed 420 mg per day (3 capsules per day).

Approval duration: 6 months

D. Marginal Zone Lymphoma (must meet all)**:**
1. Diagnosis of MZL;
2. Age ≥ 18 years;
3. Member has received at least one prior anti-CD20-based therapy (e.g., rituximab), unless contraindicated;
4. Dose does not exceed 560 mg per day (4 capsules per day).

Approval duration: 6 months

E. Chronic Graft-versus-Host Disease (must meet all)**:**
1. Diagnosis of cGVHD;
2. Member has a history of bone marrow/stem cell transplant;
3. Prescribed by or in consultation with an oncologist, hematologist, or bone marrow transplant specialist;
4. Age ≥ 18 years;
5. One of the following (a or b):
   a. Member has failed to respond, has progressed (see Appendix B), or has experienced clinically significant adverse effects to systemic corticosteroid treatment (e.g., prednisone);
   b. If member has contraindication(s) to corticosteroid treatment, failure of at least one prior line of systemic therapy for cGVHD (see Appendix B), unless all are contraindicated;
6. Dose does not exceed 420 mg per day (3 capsules per day).

Approval duration: 6 months

F. Hairy Cell Leukemia (off-label) (must meet all)**:**
1. Diagnosis of hairy cell leukemia;
2. Used as a single-agent therapy for member with disease progression;

3. Documentation supports failure of or presence of clinically significant adverse effects or contraindication to at least two FDA approved medications for hairy cell leukemia (e.g., cladribine, pentostatin, interferon alfa);
4. Request meets one of the following (a or b):
   a. Dose does not exceed 560 mg per day (4 capsules per day);
   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

G. Other diagnoses/indications

1. Refer to HIM.PHAR.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. MCL, CLL/SLL, SM, MZL and cGVHD (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy (e.g., no disease progression, no unacceptable toxicity);
3. If request is for a dose increase, new dose does not exceed the following:
   a. For MCL and MZL: 560 mg per day (4 capsules per day);
   b. For CLL/SLL, WM, and cGVHD: 420 mg per day (3 capsules per day).

Approval duration: 12 months

B. Hairy Cell Leukemia (off-label) (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
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 560 mg per day (4 capsules 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*).

Approval duration: 12 months

C. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via health plan benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to HIM.PA.21 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 – HIM.PHAR.21 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CLL: chronic lymphocytic leukemia
cGVHD: chronic graft-versus-host disease
FDA: Food and Drug Administration
MCL: mantle cell lymphoma
MZL: marginal zone lymphoma
SLL: small lymphocytic lymphoma
WM: Waldenström's macroglobulinemia

Appendix B: General Information

- cGVHD:
  - The National Institutes of Health Working Group recommends that the diagnosis of cGVHD require at least 1 diagnostic manifestation of cGVHD (e.g., poikiloderma or esophageal web) or at least 1 distinctive manifestation (e.g., keratoconjunctivitis sicca) confirmed by pertinent biopsy or other relevant tests in the same or another organ.
  - Corticosteroids are the mainstay of initial systemic treatment for patients with cGVHD. In addition to corticosteroids, components of second-line pharmacologic treatments include, but are not limited to, mycophenolate mofetil, calcineurin inhibitors (e.g., cyclosporine, tacrolimus), sirolimus, and rituximab.
  - Steroid-refractory chronic GVHD is defined as either failure to improve after at least 2 months, or progression after 1 month of standard immunosuppressive therapy, including corticosteroids and cyclosporine.

V. References

1. Imbruvica Prescribing Information. Sunnyvale, CA: Pharmacyclics LLC; August 2017. Available at: https://www.imbruvica.com/. Accessed August 31, 2017.
2. Ibrutinib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.NCCN.org. Accessed August 21, 2017.
3. B-cell lymphomas (Version 3.2017). In: National Comprehensive Cancer Network Guidelines. Available at www.NCCN.org. Accessed August 31, 2017.
4. Ruutu T, Gratwohl A, de Witte T, et al. Prophylaxis and treatment of GVHD: EBMT-ELN working group recommendations for a standardized practice. Bone Marrow Transplant. 2014 Feb;49(2):168-73.
5. Lee SJ, Vogelsang G, Flowers ME. Chronic graft-versus-host disease. Biol Blood Marrow Transplant 2003; 9:215-233.
6. Filipovich, AH, Weisdorf D, Pavletic S., et al. National Institutes of Health Consensus Development Project on Criteria for Clinical Trials in Chronic Graft-versus-Host Disease: I. Diagnosis and Staging Working Group Report. Biol Blood Marrow Transplant. 2005 Dec;11(12):945-56.
7. National Comprehensive Cancer Network. Hairy Cell Leukemia Version 2.2017. Available at: https://www.nccn.org/professionals/physician_gls/pdf/hairy_cell.pdf. Accessed August 21, 2017.
8. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2017. Available at: http://www.clinicalpharmacology-ip.com/.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	08.31.17	11.17

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. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. 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. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.