Clinical Policy: Niraparib (Zejula)

Reference Number: CP.PHAR.408
Effective Date: 05.09.17
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

Niraparib (Zejula®) is a poly(ADP-ribose) polymerase (PARP) inhibitor.

FDA Approved Indication(s)

Zejula is indicated for the:

- Maintenance treatment of adult patients with advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to first-line platinum-based chemotherapy
- Maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy
- Treatment of adult patients with advanced ovarian, fallopian tube, or primary peritoneal cancer who have been treated with three or more prior chemotherapy regimens and whose cancer is associated with homologous recombination deficiency (HRD) positive status defined by either:
  - a deleterious or suspected deleterious BRCA mutation, or
  - genomic instability and who have progressed more than six months after response to the last platinum-based chemotherapy

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 Centene Corporation® that Zejula is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Ovarian Cancer (must meet all)**:**

1. Diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Member meets one of the following (a, b, or c):
   a. Both i and ii:
      i. Disease is associated with HRD positive status defined by one of the following (1 or 2):
         1) Documentation of deleterious or suspected deleterious germline BRCA mutation;

2) Documentation of genomic instability, and disease has progressed > 6 months after response to the last platinum-based chemotherapy;

ii. Failure of ≥ 3 prior chemotherapy regimens (*see Appendix B*), unless contraindicated or clinically significant adverse effects are experienced;

b. Completed ≥ 2 platinum-based chemotherapy regimens and is in a complete or partial response;

c. Both i and ii:

i. Newly diagnosed stage II-IV disease;

ii. Completed first-line platinum-based chemotherapy regimen and is in a complete or partial response;

5. Zejula is prescribed in one of the following ways (a or b):
   a. As a single agent;
   b. In combination with bevacizumab for platinum-sensitive persistent disease or recurrence for radiographic and/or clinical relapse in patients with previous complete remission and relapse after ≥ 6 months after completing prior chemotherapy;
6. Member has not previously received a PARP inhibitor (e.g., Lynparza®, Rubraca®, Talzenna®);
7. Request meets one of the following (a or b):*
   a. Dose does not exceed 300 mg (3 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*).

**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 the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Ovarian Cancer (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Zejula 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 300 mg (3 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*).

**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 Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

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 policies – CP.CPA.09 for commercial and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
HRD: homologous recombination deficiency
PARP: poly(ADP-ribose) polymerase

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
Ovarian Cancer		
Alimta® (pemetrexed)	Various	Varies
Alkeran® (melphalan)	Various	Varies
Avastin® (bevacizumab)	Various	Varies
carboplatin (Paraplatin®)	Various	Varies
cisplatin (Platinol-AQ®)	Various	Varies
cyclophosphamide (Cytoxan®)	Various	Varies
docetaxel (Taxotere®)	Various	Varies
doxorubicin (Doxil®, Adriamycin®)	Various	Varies
etoposide (Vepesid®)	Various	Varies
gemcitabine (Gemzar®)	Various	Varies
ifosfamide (Ifex®)	Various	Varies
irinotecan (Camptosar®)	Various	Varies
oxaliplatin (Eloxatin®)	Various	Varies
topotecan (Hycamtin®)	Various	Varies
Hexalen® (altretamine)	Various	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

Appendix D: General Information

- There are insufficient data regarding the use of consecutive PARP inhibitors. Most PARP inhibitor pivotal trials excluded prior PARP inhibitor use, the NCCN does not make any explicit recommendations (other than for ovarian cancer, where they state data is limited), and there are no randomized controlled trials evaluating such use.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Ovarian, fallopian tube, or primary peritoneal cancer	300 mg PO QD	300 mg/day

VI. Product Availability

Capsule: 100 mg

VII. References

1. Zejula Prescribing Information. Waltham, MA: Tesaro, Inc.; April 2020. Available at: https://www.zejula.com. Accessed April 30, 2020.
2. Niraparib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed May 15, 2020.
3. National Comprehensive Cancer Network. Ovarian Cancer Version 1.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ovarian.pdf. Accessed May 15, 2020.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created. Adopted from CP.CPA.200 Niraparib (Zejula)	11.20.18	02.19
1Q 2020 annual review: criteria added for expanded FDA-indication in advanced ovarian, fallopian tube, or primary peritoneal cancer after treated with three or more prior chemotherapy regimens and whose cancer is associated with HRD positive status; references reviewed and updated.	11.26.19	02.20
Criteria added for expanded FDA-indication as maintenance treatment in advanced ovarian, fallopian tube, or primary peritoneal cancer in patients who are in a complete or partial response to first-line platinum-based chemotherapy; added that Zejula must be used as a single agent or in combination with bevacizumab per NCCN recommendations; added requirement for no prior PARP inhibitor use.	06.02.20	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. 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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.