Clinical Policy: Crizotinib (Xalkori)

Reference Number: CP.PHAR.90
Effective Date: 11.01.11
Last Review Date: 05.21
Line of Business: Commercial, HIM, Medicaid

Revision Log

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

Description

Crizotinib (Xalkori®) is a kinase inhibitor.

FDA Approved Indication(s)

Xalkori is indicated for the treatment of:

- Patients with metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK) or ROS1-positive as detected by an FDA-approved test.
- Pediatric patients 1 year of age and older and young adults with relapsed or refractory, systemic anaplastic large cell lymphoma (ALCL) that is ALK-positive.

Limitation(s) of use: The safety and efficacy of Xalkori have not been established in older adults with relapsed or refractory, systemic ALK-positive ALCL.

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 Xalkori 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. Disease is ALK, ROS1 or MET positive;
5. For Xalkori requests, member must use generic crizotinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 500 mg (2 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/HIM – 6 months
Commercial – Length of Benefit

B. Anaplastic Large Cell Lymphoma (must meet all)**:**
1. Diagnosis of relapsed or refractory ALCL (a peripheral T-cell lymphoma);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 1 year;
4. Disease is ALK positive;
5. For Xalkori requests, member must use generic crizotinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 560 mg/m^2 (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)*.

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months
Commercial – Length of Benefit

C. Inflammatory Myofibroblastic Tumor (off-label) (must meet all)**:**
1. Diagnosis of inflammatory myofibroblastic tumor (a soft tissue sarcoma);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is ALK positive;
5. For Xalkori requests, member must use generic crizotinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Dose is within FDA maximum limit for any FDA-approved indication or 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/HIM – 6 months
Commercial – Length of Benefit

D. 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, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Xalkori for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Xalkori requests, member must use generic crizotinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, request meets one of the following (a, b, or c):*
   a. NSCLC: New dose does not exceed 500 mg (2 capsules) per day;

b. ALCL: New dose does not exceed 560 mg/m^2 (4 capsules) per day;
c. 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/HIM – 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, HIM.PA.154 for health insurance marketplace, 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, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALK: anaplastic lymphoma kinase
ALCL: anaplastic large cell lymphoma
FDA: Food and Drug Administration
MET: mesenchymal-epithelial transition
NCCN: National Comprehensive Cancer Network
NSCLC: non-small cell lung cancer
ROS1: ROS proto-oncogene 1

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
NSCLC	250 mg PO BID	500 mg/day
ALCL	280 mg/m^2 PO BID	560 mg/m^2/day

VI. Product Availability

Capsules: 200 mg, 250 mg

VII. References

1. Xalkori Prescribing Information. New York, NY: Pfizer, Inc.; January 2021. Available at http://labeling.pfizer.com/showlabeling.aspx?id=676. Accessed January 20, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed January 12, 2021.
3. National Comprehensive Cancer Network Guidelines. Non-Small Cell Lung Cancer Version 2.2021. Available at www.nccn.org. Accessed January 12, 2021.
4. National Comprehensive Cancer Network Guidelines. Central Nervous System Cancers Version 3.2020. Available at www.nccn.org. Accessed January 12, 2021.
5. National Comprehensive Cancer Network Guidelines. Soft Tissue Sarcoma Version 1.2021. Available at www.nccn.org. Accessed January 12, 2021.
6. National Comprehensive Cancer Network Guidelines. T-Cell Lymphomas Version 1.2021. Available at www.nccn.org. Accessed January 12, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Maximum and minimum doses added. Reasons to discontinue removed. Approval periods increase from 3/6 to 6/12 months.	07.17	08.17
2Q 2018 annual review: policies combined for Commercial and Medicaid; added HIM line of business; age added; minimum dose removed; off-label NSCLC recurrent disease added; off-label ALCL added; summarized NCCN and FDA approved uses for improved clarity; added specialist involvement in care; added continuity of care statement; references reviewed and updated.	02.13.18	05.18
2Q 2019 annual review: NCCN designation of advanced added to NSCLC; references reviewed and updated.	02.19.19	05.19
2Q 2020 annual review: revised continued approval duration from 6 to 12 months; references reviewed and updated.	02.11.20	05.20
2Q 2021 annual review: RT4: updated with FDA-approved indication for ALCL (previously included as an NCCN supported off-label use) with age 1 year or older and dosing limits per label; oral oncology generic redirection language added; revised reference to HIM off-label use policy from HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	01.12.21	05.21

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.