Clinical Policy: Elacestrant (Orserdu)

Reference Number: CP.PHAR.623
Effective Date: 06.01.23
Last Review Date: 05.24
Line of Business: Commercial, HIM, Medicaid

Revision Log

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

Description

Elacestrant (Orserdu®) is an estrogen receptor antagonist.

FDA Approved Indication(s)

Orserdu is indicated for the treatment of postmenopausal women or adult men, with ER-positive, HER2-negative, ESR1-mutated advanced or metastatic breast cancer with disease progression following at least one line of endocrine therapy.

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 Orserdu is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Member meets one of the following (a or b):
   a. Diagnosis of advanced, recurrent unresectable, or stage IV (M1) metastatic breast cancer;
   b. Diagnosis of inflammatory breast cancer with no response to preoperative systemic therapy;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For Orserdu requests, member must use elacestrant, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. Disease has all of the following characteristics (a, b, and c):
   a. Estrogen receptor (ER) positive;
   b. Human epidermal growth factor receptor 2 (HER2)-negative;
   c. Estrogen receptor 1 (ERS1)-mutated;
6. Member meets one of the following (a or b):
   a. Disease has progressed following at least one line of endocrine therapy (e.g., exemestane, fulvestrant, anastrozole, letrozole, tamoxifen);
   b. Member has visceral crisis*, defined as severe organ dysfunction, as assessed by signs and symptoms, laboratory studies, and rapid progression of disease;
   **Visceral crisis is not the mere presence of visceral metastases but implies important organ compromise leading to a clinical indication for the most rapidly efficacious therapy.*

7. Member has received prior treatment with a CDK4/6 inhibitor (e.g., Ibrance®, Verzenio®, Kisqali®);
8. If member is a biological female, member is postmenopausal or premenopausal treated with ovarian ablation/suppression (*see Appendix D for diagnosis of menopause*);
9. Used as a single agent therapy;
10. Request meets one of the following (a or b):*
    a. Dose does not exceed both (i and ii):
        i. 345 mg per day;
        ii. 3 tablets 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 – 12 months or duration of request, whichever is less

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
    a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
    b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

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

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Orserdu for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Orserdu requests, member must use elacestrant, 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 or b):*
    a. New dose does not exceed both (i and ii):
        i. 345 mg per day;

ii. 3 tablets 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/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: 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

ER: estrogen receptor
ERS1: estrogen receptor 1
FDA: Food and Drug Administration
HER2: human epidermal growth factor receptor 2
HR: hormone receptor

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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Endocrine Therapy		
anastrozole (Arimidex®)	1 mg PO QD	1 mg/day
exemestane (Aromasin®)	25 mg PO QD	25 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
toremifene (Fareston®)	60 mg PO QD	60 mg/day
fulvestrant (Faslodex®)	500 mg IM into the buttocks slowly (1 - 2 minutes per injection) as two 5 mL injections, one in each buttock, on days 1, 15, 29 and once monthly thereafter	500 mg/day
letrozole (Femara®)	2.5 mg PO QD	2.5 mg/day
tamoxifen (Soltamox®)	20 to 40 mg PO QD	40 mg/day
megestrol acetate	40 mg PO QID	160 mg/day
CDK4/6 Inhibitors		
Ibrance® (palbociclib)	125 mg PO QD for 21 consecutive days followed by 7 days off treatment	125 mg/day
Verzenio® (abemaciclib)	In combination with fulvestrant or an aromatase inhibitor: 150 mg PO BID As monotherapy: 200 mg PO BID	Combination therapy: 300 mg/day Monotherapy: 400 mg/day
Kisqali® (ribociclib)	600 mg PO QD for 21 consecutive days followed by 7 days off	600 mg/day

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information
- Per NCCN, evidence-based criteria for the diagnosis of menopause in patients with breast cancer are lacking. Clinical trials in breast cancer have utilized a variety of definitions of menopause. Reasonable criteria for determining menopause in patients with breast cancer include any of the following:
  - Prior bilateral oophorectomy
  - Age ≥ 60 years
  - Age < 60 years with amenorrhea for ≥ 12 months in the absence of prior chemotherapy, receipt of tamoxifen, toremifene, or ovarian suppression and estradiol and FSH in the post-menopausal range
  - Age < 60 years and chemotherapy-induced amenorrhea for ≥ 12 months with FSH and estradiol in post-menopausal range on serial assessments
  - Age < 60 years and on tamoxifen with FSH and estradiol level in post-menopausal range
  - Menopausal status cannot be determined in those receiving ovarian function suppression

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Breast cancer	345 mg PO QD	345 mg/day

VI. Product Availability

Tablets: 86 mg, 345 mg

VII. References

1. Orserdu Prescribing Information. New York, NY: Stemline Therapeutics, Inc.; November 2023. Available at: www.orserdu.com. Accessed February 13, 2024.
2. National Comprehensive Cancer Network. Breast Cancer Version 1.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed February 13, 2024.
3. Bidard FC, Kaklamani VG, Neven P, et al. Elacestrant (oral selective estrogen receptor degrader) versus standard endocrine therapy for estrogen receptor-positive, human epidermal growth factor receptor 2-negative advanced breast cancer: results from the randomized phase III EMERALD trial. J Clin Oncol. 2022;40(28):3246-3256. doi:10.1200/JCO.22.00338

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	03.03.23	05.23
2Q 2024 annual review: clarified diagnosis of postmenopausal women; revised quantity limit from 1 tablet per day to 3 tablets per day per PI dosage modifications for adverse reactions; references reviewed and updated.	02.13.24	05.24

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.