Clinical Policy: Lomustine (Gleostine)

Reference Number: CP.PHAR.507
Effective Date: 12.01.20
Last Review Date: 11.23
Line of Business: Commercial, HIM, Medicaid

Revision Log

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

Description

Lomustine (Gleostine®) is a nitrosourea and an alkylating agent.

FDA Approved Indication(s)

Gleostine is indicated for the treatment of patients with:

- Brain tumors, primary and metastatic, following appropriate surgical and/or radiotherapeutic procedures;
- Hodgkin's lymphoma in combination with other chemotherapies, following disease progression with initial 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 Gleostine is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Brain Tumors (must meet all)**:**

1. Diagnosis of brain tumor;
2. Prescribed by or in consultation with an oncologist;
3. For brand Gleostine requests, member must use generic lomustine, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. Request meets one of the following (a or b):*
   a. Dose does not exceed 130 mg/m^2 every 6 weeks;
   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: 6 months

B. Hodgkin's Lymphoma (must meet all)**:**

1. Diagnosis of Hodgkin's lymphoma;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Failure of an initial chemotherapy regimen *(see Appendix B for examples)*, unless contraindicated or clinically significant adverse effects are experienced;
4. Prescribed in combination with chemotherapy;

5. For brand Gleostine requests, member must use generic lomustine, 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 130 mg/m^2 every 6 weeks;
   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: 6 months

C. 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. All Indications in Section I (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. For brand Gleostine requests, member must use generic lomustine, 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 130 mg/m^2 every 6 weeks;
   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: 12 months

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
FDA: Food and Drug Administration
NCCN: National Comprehensive Cancer Network

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
Temozolomide (Temodar®)	Brain Tumors Glioblastoma multiforme: 75 mg/m^2 PO QD for 42 days followed by maintenance therapy for 6 cycles with cycle 1 including temozolomide 150 mg/m^2 PO QD for 5 days followed by 23 days without treatment and cycles 2-6 consisting of temozolomide 200 mg/m^2 PO QD for the first 5 days of each cycle	200 mg/m^2/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Anaplastic astrocytoma: 150 mg/m^2 PO QD for 5 days of each 28-day treatment cycle	
Doxorubicin, bleomycin, vinblastine, dacarbazine (ABVD)	Hodgkin's Lymphoma Varies per protocol and patient tolerance	Varies
Doxorubicin, vinblastine, mechlorethamine, etoposide, vincristine, bleomycin, prednisone (Stanford V)	Hodgkin's Lymphoma Varies per protocol and patient tolerance	Varies
Bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, prednisone (Escalated BEACOPP)	Hodgkin's Lymphoma Varies per protocol and patient tolerance	Varies
Brentuximab vedotin, doxorubicin, vinblastine, dacarbazine (Adcetris® + AVD)	Hodgkin's Lymphoma Varies per protocol and patient tolerance	Varies
Cyclophosphamide, doxorubicin, vincristine, prednisone, rituximab (CVP + Rituxan®)	Hodgkin's Lymphoma Varies per protocol and patient tolerance	Varies
Rituximab (Rituxan®)	Hodgkin's Lymphoma Varies per protocol and patient tolerance	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

- Contraindication(s): none reported
- Boxed warning(s):
  - Delayed myelosuppression
  - Risk of overdosage

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Brain tumors, Hodgkin's lymphoma	130 mg/m^2 PO one time every 6 weeks	130 mg/m^2 every 6 weeks

VI. Product Availability

Capsules: 5 mg, 10 mg, 40 mg, 100 mg

VII. References

1. Gleostine Prescribing Information. Miami, FL: NextSource Biotechnology; September 2018. Available at: https://www.nextsourcepharma.com/docs/pi/Gleostine-PI.pdf. Accessed August 10, 2023.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed August 10, 2023.
3. National Comprehensive Cancer Network. Central Nervous System Cancers Version 1.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf. Accessed August 10, 2023.
4. National Comprehensive Cancer Network. Hodgkin Lymphoma Version 2.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/hodgkins.pdf. Accessed August 10, 2023.
5. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed August 10. 2023.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created: adapted from previously approved policy HIM.PA.19; retire HIM.PA.19; added Commercial and Medicaid lines of business; no significant changes from previously approved policy; 4Q 2020 annual review: no significant changes; references reviewed and updated.	08.03.20	11.20
4Q 2021 annual review: for brain tumors, removed temozolomide re-direction per SDC; for Hodgkin's lymphoma, added requirement for combination use per FDA label; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	06.28.21	11.21
4Q 2022 annual review: no significant changes; revised FDA approved indication to mirror prescribing information; added previously P&T-approved template redirection to generic equivalents when available; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section.	08.09.22	11.22
4Q 2023 annual review: no significant changes; references reviewed and updated.	08.10.23	11.23

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.