Clinical Policy: Trabectedin (Yondelis)
Reference Number: CP.PHAR.204
Effective Date: 05.01.16
Last Review Date: 02.19
Line of Business: HIM-Medical Benefit, Medicaid

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

Description
Trabectedin (Yondelis®) is an alkylating drug.

FDA Approved Indication(s)
Yondelis is indicated for the treatment of patients with unresectable or metastatic liposarcoma (LPS) or leiomyosarcoma (LMS) who received a prior anthracycline-containing regimen.

Policy/Criteria
Provider must submit documentation (including 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 Yondelis is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Soft Tissue Sarcoma (must meet all):
      1. Diagnosis of unresectable or metastatic soft tissue sarcoma (STS);
      2. Prescribed by or in consultation with an oncologist;
      3. Age ≥ 18 years;
      4. If uterine leiomyosarcoma (uLMS), member has received a prior anthracycline-containing regimen (e.g., doxorubicin);
      5. Request meets one of the following (a or b):
         a. Dose does not exceed 1.5 mg/m² body surface area every 3 weeks;
         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

   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.PMN.53 for Medicaid and HIM-Medical Benefit.

II. Continued Therapy
   A. Soft Tissue Sarcoma (must meet all):
      1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Yondelis 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 1.5 mg/m² body surface area every 3 weeks;
   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**

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.PMN.53 for Medicaid and HIM-Medical Benefit.

**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 – CP.PMN.53 or evidence of coverage documents.

**IV. Appendices/General Information**

**Appendix A: Abbreviation/Acronym Key**
- FDA: Food and Drug Administration
- LMS: leiomyosarcoma
- LPS: liposarcoma
- STS: soft tissue sarcoma
- uLMS: uterine leiomyosarcoma

**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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>uLMS - examples of anthracycline-containing regimens: doxorubicin ± gemcitabine, olaratumab, fosfamide, or dacarbazine; epirubicin; liposomal doxorubicin</td>
<td>Varies</td>
<td>Varies</td>
</tr>
</tbody>
</table>

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): Known hypersensitivity to trabectedin
- Boxed warning(s): None reported
V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>LPS, LMS</td>
<td>1.5 mg/m² (body surface area) as a 24-hour IV infusion every 21 days (3 weeks), until disease progression or unacceptable toxicity</td>
<td>Varies</td>
</tr>
</tbody>
</table>

VI. Product Availability

Single-dose vial with powder for injection: 1 mg

VII. References


Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9352</td>
<td>Injection, trabectedin, 0.1 mg</td>
</tr>
</tbody>
</table>

Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>04.16</td>
<td>05.16</td>
</tr>
<tr>
<td>03.17</td>
<td>04.17</td>
</tr>
<tr>
<td>10.30.17</td>
<td>02.18</td>
</tr>
</tbody>
</table>

- Initial: Added age requirement as safety and efficacy have not been established in pediatric patients.
- Removed criteria around specific FDA/NCCN uses that are under the purview of the provider, and added prescriber requirement to ensure appropriate use.
**Clinical Policy**

**Trabectedin**

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Require that use be for palliative therapy or for metastatic or unresectable disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Re-auth: Added COC for STS. Modified requirement for no disease progression or unacceptable toxicity to requirement for positive response to therapy. Both: Added max dosing criteria. -References reviewed and updated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1Q 2019 annual review; HIM-Medical Benefit line of business added; coverage of STS is expanded to encompass STS subtypes of non-specific histologies per NCCN; references reviewed and updated.</td>
<td>11.13.18</td>
<td>02.19</td>
</tr>
</tbody>
</table>

**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.

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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.

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