Clinical Policy: Gefitinib (Iressa)
Reference Number: CP.PHAR.299
Effective Date: 01.01.17
Last Review Date: 11.17
Line of Business: Medicaid

Coding Implications
Revision Log

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

Description
Gefitinib (Iressa®) is a tyrosine kinase inhibitor.

FDA Approved Indication(s)
Iressa is indicated for first-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test.

Limitation(s) of use: Safety and efficacy of Iressa have not been established in patients with metastatic NSCLC whose tumors have EGFR mutations other than exon 19 deletions or exon 21 (L858R) substitution mutations.

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of health plans affiliated with Centene Corporation® that Iressa 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 or metastatic NSCLC;
      2. Disease is positive for a sensitizing EGFR mutation (exon 19 deletion or exon 21 [L858R] substitution) as detected by an FDA approved test;
      3. Age ≥ 18 years;
      4. Iressa is prescribed as first-line therapy;
      5. Dose does not exceed 250 mg per day (Note: If Iressa is administered with a strong CYP3A4 inducer [e.g., rifampicin, phenytoin, tricyclic antidepressants], prescribed dose of Iressa does not exceed 500 mg per day).

   Approval duration: 6 months

   B. Other diagnoses/indications
      1. Refer to CP.PHAR.57 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).
II. Continued Therapy

A. Non-Small Cell Lung Cancer (must meet all):
   1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   2. If Iressa is requested after disease progression on Iressa, NSCLC is characterized by any of the following (off-label NCCN recommended use):
      a. Asymptomatic disease (without rapid radiologic progression or threatened organ function);
      b. Symptomatic brain lesions;
      c. Isolated symptomatic systemic lesions;
   3. If request is for a dose increase, request meets one of the following (a or b):
      a. New dose does not exceed 250 mg per day (Note: If Iressa is administered with a strong CYP3A4 inducer [e.g., rifampicin, phenytoin, tricyclic antidepressants], prescribed dose of Iressa does not exceed 500 mg 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).

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 CP.PHAR.57 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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. PHAR.57 or evidence of coverage documents.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   EGFR: epidermal growth factor receptor
   FDA: Food and Drug Administration
   NSCLC: non-small cell lung cancer

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
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<tbody>
<tr>
<td>NSCLC</td>
<td>250 mg per day</td>
<td>250 mg per day (Note: If Iressa is administered with a strong CYP3A4 inducer [e.g., rifampicin, phenytoin, tricyclic antidepressants], prescribed dose of Iressa does not exceed 500 mg per day).</td>
</tr>
</tbody>
</table>

VI. Product Availability
CLINICAL POLICY
Gefitinib

Tablets: 250 mg

VII. References

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tr>
<td>J8565</td>
<td>Gefitinib, oral, 250 mg</td>
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Reviews, Revisions, and Approvals

- New policy. 11.01.16 01.17
- Updated references and template. Changed approval duration from 3/6 months to 6/12 months. Updated policy with new safety strategy and added age. 08.18.17 11.17

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.

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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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