Clinical Policy: Daunorubicin/Cytarabine (Vyxeos)
Reference Number: CP.PHAR.352
Effective Date: 12.01.17
Last Review Date: 11.20
Line of Business: HIM, Medicaid

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

Description
Daunorubicin/cytarabine (Vyxeos®) is a liposomal combination of daunorubicin, an anthracycline topoisomerase inhibitor, and cytarabine, a nucleoside metabolic inhibitor.

FDA Approved Indication(s)
Vyxeos is indicated for the treatment of adults with newly-diagnosed therapy-related acute myeloid leukemia (t-AML) or AML with myelodysplasia-related changes (AML-MRC).

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 Vyxeos is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Acute Myeloid Leukemia (must meet all):
      1. Diagnosis of AML;
      2. Prescribed by or in consultation with an oncologist or hematologist;
      3. Age ≥ 18 years;
      4. Request meets one of the following (a, b, or c)*:
         a. Induction (up to 2 cycles): dose does not exceed 44 mg/m² daunorubicin liposomal and 100 mg/m² cytarabine liposomal on days 1, 3, and 5 of cycle 1, and days 1 and 3 if a second cycle;
         b. Consolidation (up to 2 cycles): dose does not exceed 29 mg/m² daunorubicin liposomal and 65 mg/m² cytarabine liposomal on days 1 and 3 of each cycle;
         c. 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. 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): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.
II. Continued Therapy

A. Acute Myeloid Leukemia (must meet all):
   1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Vyxeos for a covered indication and has received this medication for at least 30 days;
   2. Member is responding positively to therapy;
   3. Member has not yet received ≥ 4 treatment cycles (up to 2 induction and 2 consolidation cycles);
   4. If request is for a dose increase, request meets one of the following (a, b, or c)*:
      a. Induction (up to 2 cycles total): new dose does not exceed 44 mg/m² daunorubicin liposomal and 100 mg/m² cytarabine liposomal on days 1, 3, and 5 of cycle 1, and days 1 and 3 if a second cycle;
      b. Consolidation (up to 2 cycles total): new dose does not exceed 29 mg/m² daunorubicin liposomal and 65 mg/m² cytarabine liposomal on days 1 and 3 of each cycle;
      c. 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. 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): HIM.PHAR.21 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 policy – HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AML: acute myeloid leukemia
AML-MRC: acute myeloid leukemia with myelodysplasia-related changes
FDA: Food and Drug Administration

NCCN: National Comprehensive Cancer Network
t-AML: therapy-related acute myeloid leukemia

Appendix B: Therapeutic Alternatives
Not applicable
Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): hypersensitivity to daunorubicin, cytarabine, or any component of the formulation
- Boxed warning(s): do not interchange with other daunorubicin and/or cytarabine-containing products

V. Dosage and Administration

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<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
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| AML        | A full Vyxeos course consists of 1-2 cycles of induction and up to 2 cycles of consolidation.  
- **First Induction:** Daunorubicin 44 mg/m² and cytarabine 100 mg/m² liposome IV over 90 minutes on days 1, 3 and 5  
- **Second Induction** (Only for patients failing to achieve a response with the first induction cycle; administered 2 to 5 weeks after the first): Daunorubicin 44 mg/m² and cytarabine 100 mg/m² liposome IV over 90 minutes on days 1 and 3  
- **Consolidation:** Daunorubicin 29 mg/m² and cytarabine 65 mg/m² liposome IV over 90 minutes on days 1 and 3. Administer the first consolidation cycle 5 to 8 weeks after the start of the last induction; administer the second consolidation cycle 5 to 8 weeks after the start of the first consolidation cycle in patients who do not show disease progression or unacceptable toxicity to Vyxeos. | See dosing regimens |

VI. Product Availability

Single-dose vial: 44 mg daunorubicin and 100 mg cytarabine

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>
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<tbody>
<tr>
<td>C9024</td>
<td>Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine</td>
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<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>Policy created</td>
<td>09.06.17</td>
<td>11.17</td>
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<tr>
<td>4Q 2018 annual review: no significant changes; HIM-Medical added; added specialist prescriber requirement; added continuation of therapy language to Section II; references reviewed and updated.</td>
<td>07.23.18</td>
<td>11.18</td>
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<td>4Q 2019 annual review: antecedent MDS/CMML added per NCCN; cycle details added per PI; FDA/NCCN dosing limitation added; references reviewed and updated.</td>
<td>08.20.19</td>
<td>11.19</td>
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<tr>
<td>4Q 2020 annual review: modified HIM-Medical Benefit to HIM line of business; AML criteria collapsed in recognition of the interrelated transformative nature of the three disease states and to encompass new subtypes and treatment algorithms; references reviewed and updated.</td>
<td>08.18.20</td>
<td>11.20</td>
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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
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