Clinical Policy: Abemaciclib (Verzenio)
Reference Number: CP.PHAR.355
Effective Date: 10.24.17
Last Review Date: 11.19
Line of Business: Commercial, Medicaid

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

Description
Abemaciclib (Verzenio®) is an inhibitor of cyclin-dependent kinases 4 and 6 (CDK4/6).

FDA Approved Indication(s)
Verzenio is indicated:
- In combination with an aromatase inhibitor as initial endocrine-based therapy for the treatment of postmenopausal women with HR-positive, HER2-negative advanced or metastatic breast cancer
- In combination with fulvestrant for the treatment of women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer with disease progression following endocrine therapy
- As monotherapy for the treatment of adult patients with HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy and prior chemotherapy in the metastatic setting

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 Verzenio is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Breast Cancer (must meet all):
      1. Diagnosis of breast cancer;
      2. Prescribed by or in consultation with an oncologist;
      3. Age ≥ 18 years;
      4. Disease has all of the following characteristics (a, b, and c):
         a. HR-positive (i.e., estrogen receptor (ER) and/or progesterone receptor (PR) positive);
         b. HER2-negative;
         c. Advanced (locally recurrent) or metastatic;
      5. Verzenio is prescribed in one of the following ways (a, b, or c):
         a. In combination with fulvestrant after disease progression on an endocrine therapy;
         b. As a single agent after disease progression on an endocrine therapy and chemotherapy (e.g., docetaxel, gemcitabine);
c. In combination with an aromatase inhibitor (e.g., letrozole, anastrozole, exemestane), and:
   i. If male, an agent that suppresses testicular steroidogenesis (e.g., gonadotropin-releasing hormone agonists);
6. Request meets one of the following (a or b):*
   a. Dose does not exceed one of the following (i or ii):
      i. For combination therapy: 300 mg per day (two 150 mg tablets per day);
      ii. For monotherapy: 400 mg per day (two 200 mg 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 – 6 months
Commercial – Length of Benefit

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.CPA.09 for commercial 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 Verzenio for breast cancer and has received this medication for at least 30 days;
   2. Member is responding positively to therapy;
   3. Dose is ≥ 100 mg/day;
   4. If request is for a dose increase, request meets one of the following (a or b):*
      a. New dose does not exceed one of the following (i or ii):
         i. For combination therapy: 300 mg per day (two 150 mg tablets per day);
         ii. For monotherapy: 400 mg per day (two 200 mg tablets per day);
      b. New dose is supported by practice guideline 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 – 12 months
Commercial – Length of Benefit

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.CPA.09 for commercial 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 and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
- CDK: cyclin-dependent kinase
- ER: estrogen receptor
- FDA: Food and Drug Administration
- HER2: human epidermal growth factor receptor 2
- HR: hormone receptor
- NCCN: National Comprehensive Cancer Network
- PR: progesterone 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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Endocrine Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>anastrozole (Arimidex®)</td>
<td>1 mg PO QD</td>
<td>1 mg/day</td>
</tr>
<tr>
<td>exemestane (Aromasin®)</td>
<td>25 mg PO QD</td>
<td>25 mg/day</td>
</tr>
<tr>
<td>Fareston® (toremifene)</td>
<td>60 mg PO QD</td>
<td>60 mg/day</td>
</tr>
<tr>
<td>Faslodex® (fulvestrant)</td>
<td>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</td>
<td>500 mg/day</td>
</tr>
<tr>
<td>letrozole (Femara®)</td>
<td>2.5 mg PO QD</td>
<td>2.5 mg/day</td>
</tr>
<tr>
<td>tamoxifen (Nolvadex®, Soltamox®)</td>
<td>20 to 40 mg PO QD</td>
<td>40 mg/day</td>
</tr>
<tr>
<td>megestrol acetate</td>
<td>40 mg PO QID</td>
<td>160 mg/day</td>
</tr>
<tr>
<td><strong>Chemotherapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>capecitabine (Xeloda®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>carboplatin (Paraplatin®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>cisplatin (Platinol-AQ®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>cyclophosphamide (Cytoxan®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>docetaxel (Taxotere®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>doxorubicin (Lipodox®, Doxil®, Adriamycin®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>epirubicin (Ellence®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>gemcitabine (Gemzar®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>Halaven® (eribulin)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>Ixempra® (ixabepilone)</td>
<td>Various</td>
<td>Varies</td>
</tr>
</tbody>
</table>
### Drug Name
Paclitaxel (Abraxane\textsuperscript{®}, Taxol\textsuperscript{®})
Vinorelbine (Navelbine\textsuperscript{®})

### Dosing Regimen
Various
Various

### Dose Limit/Maximum Dose
Varies
Varies

*Drug names are listed as Brand name\textsuperscript{®} (generic) when the drug is available by brand name only and generic (Brand name\textsuperscript{®}) when the drug is available by both brand and generic.*

### Appendix C: Contraindications/Boxed Warnings
None reported

### Appendix D: General Information
- The NCCN recommends that men with breast cancer be treated similarly to postmenopausal women, except that the use of an aromatase inhibitor is ineffective without concomitant suppression of testicular steroidogenesis.
- The NCCN supports use of Verzenio in premenopausal women when used concomitantly with an aromatase inhibitor or fulvestrant. Along with this combination therapy, patients should also be treated with ovarian ablation/suppression. Ovarian ablation can be achieved with surgical oophorectomy or ovarian irradiation. Ovarian suppression can be achieved with luteinizing hormone-releasing hormone agonists (e.g., goserelin, leuprolide).
- For disease progression while on a CDK4/6 inhibitor, there is no data to support retreatment with another CDK4/6 inhibitor-containing regimen.
- Fluoxymesterone and ethinyl estradiol for breast cancer are other endocrine therapies, but they are no longer commercially available.

### V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen*</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer</td>
<td>In combination with fulvestrant or an aromatase inhibitor: 150 mg PO BID</td>
<td>Combination therapy: 300 mg/day</td>
</tr>
<tr>
<td></td>
<td>As monotherapy: 200 mg PO BID</td>
<td>Monotherapy: 400 mg/day</td>
</tr>
</tbody>
</table>

*If a dose reduction to < 100 mg/day is required, therapy should be discontinued.*

### VI. Product Availability
Tablet: 50 mg, 100 mg, 150 mg, and 200 mg

### VII. References
Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created</td>
<td>10.24.17</td>
<td>11.17</td>
</tr>
<tr>
<td>New indication added for initial endocrine therapy in combination with aromatase inhibitor for breast cancer; added specialist requirement.</td>
<td>03.20.18</td>
<td>05.18</td>
</tr>
<tr>
<td>4Q 2018 annual review: added requirement for an agent that suppresses testicular steroidogenesis if male and using aromatase inhibitors per NCCN; references reviewed and updated.</td>
<td>07.06.18</td>
<td>02.19</td>
</tr>
<tr>
<td>4Q 2019 annual review: no significant changes; references reviewed and updated.</td>
<td>08.19.19</td>
<td>11.19</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.

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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