Clinical Policy: Dacomitinib (Vizimpro)
Reference Number: CP.PHAR.399
Effective Date: 10.16.18
Last Review Date: 11.20
Line of Business: Commercial, HIM, Medicaid

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

Description
Dacomitinib (Vizimpro®) is a second-generation, irreversible epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor.

FDA Approved Indication(s)
Vizimpro is indicated for the first-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) with EGFR exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test.

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 Vizimpro 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, advanced or metastatic NSCLC;
      2. Prescribed by or in consultation with an oncologist;
      3. Age ≥ 18 years;
      4. Disease is positive for a sensitizing EGFR mutation (e.g., exon 19 deletion or insertion; exon 21 point mutation - L858R, L861Q; exon 18 point mutation - G719X; exon 20 point mutation - S768I);
      5. Request meets one of the following (a or b):*
         a. Dose does not exceed 45 mg (1 tablet) 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/HIM – 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
II. Continued Therapy
   A. Non-Small Cell Lung Cancer (must meet all):
      1. Currently receiving medication via Centene benefit, or documentation supports that
         member is currently receiving Vizimpro 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 45 mg (1 tablet) 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).
   *Prescribed regimen must be FDA-approved or recommended by NCCN
   Approval duration:
   Medicaid/HIM – 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, 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 policies –
      CP.CPA.09 for commercial, 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
   EGFR: epidermal growth factor receptor
   FDA: Food and Drug Administration
   NSCLC: non-small cell lung cancer

   Appendix B: Therapeutic Alternatives
   Not applicable

   Appendix C: Contraindications/Boxed Warnings
   None reported
V. Dosage and Administration

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<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
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<tr>
<td>NSCLC</td>
<td>45 mg PO QD</td>
<td>45 mg/day</td>
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VI. Product Availability
Tablets: 15 mg, 30 mg, 45 mg

VII. References

Reviews, Revisions, and Approvals

<table>
<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>10.16.18</td>
<td>11.18</td>
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<tr>
<td>No significant changes; added HIM line of business.</td>
<td>04.18.19</td>
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<td>4Q 2019 annual review: NCCN designation of advanced added; additional examples of sensitizing EGFR mutations added consistent with NCCN; references reviewed and updated.</td>
<td>07.29.19</td>
<td>11.19</td>
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<td>4Q 2020 annual review: no significant changes; references reviewed and updated.</td>
<td>08.14.20</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 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.

**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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