Clinical Policy: Selpercatinib (LOXO-292)
Reference Number: CP.PHAR.478
Effective Date: FDA Approval Date
Last Review Date: 05.20
Line of Business: Commercial, HIM, Medicaid

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

Description
Selpercatinib (LOXO-292) is a RET inhibitor.

FDA Approved Indication(s) [Pending]
LOXO-292 is indicated for the treatment of patients with:

- Advanced RET fusion-positive non-small cell lung cancer (NSCLC)
  - Metastatic RET-fusion-positive NSCLC who require systemic therapy and have progressed following platinum-based chemotherapy and an anti-programmed cell death protein 1 (PD-1) or anti-programmed death-ligand 1 (PD-L1) therapy
- RET-mutant medullary thyroid cancer (MTC)
  - RET-mutant MTC who require systemic therapy, have progressed following prior treatment, and have no acceptable alternative treatment option
- RET fusion-positive thyroid cancer
  - Advanced RET-fusion-positive thyroid cancer who require systemic therapy, have progressed following prior treatment, and have no acceptable alternative treatment options

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that LOXO-292 is medically necessary when the following criteria are met:

I. Initial Approval Criteria*
   *Criteria will mirror the clinical information from the prescribing information once FDA-approved
   
   A. Non-Small Cell Lung Cancer (must meet all):
      1. Diagnosis of advanced RET fusion-positive NSCLC;*
      2. Prescribed by or in consultation with an oncologist;
      3. Age  ≥ 18 years;*
      4. Failure of platinum-based (e.g., cisplatin, carboplatin) chemotherapy and anti-PD-1 or anti-PD-L1 therapy* (see Appendix B);*
         *Prior authorization may be required.
      5. Request meets one of the following (a or b):*
         a. Dose does not exceed the FDA approved maximum dose;*
         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. Thyroid Cancer (must meet all):
1. Diagnosis of one of the following (a or b):
   a. RET-mutant MTC,*
   b. RET fusion-positive thyroid cancer (thyroid cancer subtypes include MTC, differentiated [Hurthle cell, papillary, follicular] thyroid carcinoma, anaplastic thyroid carcinoma);*
2. Prescribed by or in consultation with an oncologist;
3. Age $\geq$ 18 years;*
4. Tumor is unresectable, not amenable to local therapies such as radioactive iodine ablation, and has progressed following systemic therapy* (see Appendix B)*
   *Prior authorization may be required.
5. Request meets one of the following (a or b):*
   a. Dose does not exceed the FDA approved maximum dose;*
   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

C. 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, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy*
*Criteria will mirror the clinical information from the prescribing information once FDA-approved

A. All Indications in Section I (must meet all):
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving LOXO-292 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 the FDA approved maximum dose;*
   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
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, 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
- FDA: Food and Drug Administration
- MTC: medullary thyroid cancer
- NCCN: National Comprehensive Cancer Network
- NSCLC: non-small cell lung cancer
- PD-1: programmed cell death protein 1
- PD-L1: anti-programmed death-ligand 1

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>NSCLC (examples of FDA-approved anti-PD-1/PD-L1 single-agent and combination therapies)</strong>&lt;br&gt;<em>PD-1/PD-L1 monoclonal antibodies</em>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keytruda®* (pembrolizumab) as a single agent or in combination with 1) pemetrexed and either carboplatin or cisplatin 2) carboplatin and either paclitaxel or paclitaxel (protein bound)</td>
<td>Keytruda (single agent or combination therapy): 200 mg IV once every 3 weeks See prescribing information for combination therapy.</td>
<td>200 mg/3 weeks</td>
</tr>
<tr>
<td>Tecentriq®* (atezolizumab) as a single agent or in combination with 1) paclitaxel (protein bound) and carboplatin 2) bevacizumab, paclitaxel, and carboplatin</td>
<td>Tecentriq (single agent): 840 mg IV every 2 weeks, or 1200 mg IV every 3 weeks, or 1680 mg IV every 4 weeks. See prescribing information for combination therapy.</td>
<td>See dosage regimens and prescribing information</td>
</tr>
<tr>
<td>Opdivo®* (nivolumab)</td>
<td>Opdivo: 240 mg IV once every 2 weeks or 480 mg IV once every 4 weeks</td>
<td>See dosage regimens</td>
</tr>
</tbody>
</table>

**Thyroid Cancer (examples of FDA-approved systemic therapies)**
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lenvima® (lenvatinib)</td>
<td>Thyroid cancer, differentiated 24 mg PO QD</td>
<td>24 mg/day</td>
</tr>
<tr>
<td>Nexavar® (sorafenib)</td>
<td>Thyroid cancer, differentiated 400 mg PO BID</td>
<td>800 mg/day</td>
</tr>
<tr>
<td>Cometriq® (cabozantinib)</td>
<td>Thyroid cancer, medullary 140 mg PO QD</td>
<td>180 mg/day</td>
</tr>
<tr>
<td>Caprelsa® (vandetanib)</td>
<td>Thyroid cancer, medullary 300 mg PO QD</td>
<td>300 mg/day</td>
</tr>
</tbody>
</table>

**Thyroid Cancer (examples of off-label chemotherapy agents)**

- Drugs used as single-agents or in chemotherapy-based regimens: carboplatin, cisplatin, paclitaxel, docetaxel, doxorubicin, dacarbazine, fluorouracil, streptozocin
- Varies based on type of thyroid cancer and disease stage.

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 [Pending]**
- Contraindication(s): pending
- Boxed warning(s): pending

**V. Dosage and Administration [Pending]**

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSCLC*</td>
<td>PO; pending</td>
<td>Pending</td>
</tr>
<tr>
<td>Thyroid cancer*</td>
<td>PO; pending</td>
<td>Pending</td>
</tr>
</tbody>
</table>

**VI. Product Availability [Pending]**

**Pending**

**VII. References**


<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created pre-emptively.</td>
<td>03.10.20</td>
<td>05.20</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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