Clinical Policy: Nilotinib (Tasigna)  
Reference Number: CP.PHAR.76  
Effective Date: 09.01.11  
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
Nilotinib (Tasigna®) is a kinase inhibitor.

FDA Approved Indication(s)
Tasigna is indicated for:

- Treatment of adult and pediatric patients greater than or equal to 1 year of age with newly diagnosed Philadelphia chromosome positive chronic myeloid leukemia in chronic phase (Ph+ CML-CP).*
- Treatment of Ph+ CML-CP and accelerated phase (Ph+ CML-AP) in adult patients resistant or intolerant to prior therapy that included imatinib.*
- Treatment of pediatric patients greater than or equal to 1 year of age with Ph+ CML-CP resistant or intolerant to prior tyrosine-kinase inhibitor (TKI) therapy.

*The effectiveness of Tasigna is based on hematologic and cytogenetic response rates.

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 Tasigna is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Chronic Myeloid Leukemia (must meet all):
      1. Diagnosis of Ph+ (BCR-ABL1-positive) CML;
      2. Prescribed by or in consultation with an oncologist or hematologist;
      3. Request meets one of the following (a or b):*
         a. Dose does not exceed 800 mg per day;
         b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

   Approval duration:
   Medicaid/HIM - 6 months
   Commercial - Length of Benefit

   B. Acute Lymphoblastic Leukemia (off-label) (must meet all):
      1. Diagnosis of Ph+ (BCR-ABL1-positive) acute lymphoblastic leukemia (ALL);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Dose is within FDA maximum limit for any FDA-approved indication or 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. Gastrointestinal Stromal Tumor (off-label) (must meet all):
1. Diagnosis of gastrointestinal stromal tumor (GIST, a soft tissue sarcoma);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Failure of imatinib (Gleevec®), Sutent® or Stivarga® unless contraindicated or clinically significant adverse effects are experienced;
   *Prior authorization may be required.
5. Dose is within FDA maximum limit for any FDA-approved indication or 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

D. 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
A. All Indications in Section I (must meet all):
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Tasigna 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 800 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).
   *Prescribed regimen must be FDA-approved or recommended by NCCN

Approval duration:
Medicaid/HIM - 6 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*
- ALL: acute lymphoblastic leukemia
- CML: chronic myeloid leukemia
- FDA: Food and Drug Administration
- GIST: gastrointestinal stromal tumor
- Ph+: positive Philadelphia chromosome

*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>imatinib (Gleevec)</td>
<td>GIST: 400 mg PO QD to 800 PO BID</td>
<td>800 mg/day</td>
</tr>
<tr>
<td>Sutent (sunitinib)</td>
<td>GIST: 50 mg PO QD</td>
<td>50 mg/day</td>
</tr>
<tr>
<td>Stivarga (regorafenib)</td>
<td>GIST: 160 mg PO QD for the first 21 days of each 28-day cycle</td>
<td>160 mg/day</td>
</tr>
</tbody>
</table>

*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*
- Contraindication(s): hypokalemia, hypomagnesemia, long QT syndrome
- Boxed warning(s): QT prolongation, sudden death

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly diagnosed Ph+ CML-CP</td>
<td>Adults: 300 mg PO BID</td>
<td>Adults: 600 mg/day</td>
</tr>
<tr>
<td>Resistant/intolerant Ph+ CML-CP or Ph+ CML-AP</td>
<td>Adults: 400 mg PO BID</td>
<td>Adults: 800 mg/day</td>
</tr>
</tbody>
</table>
### Indication | Dosing Regimen | Maximum Dose  
--- | --- | ---  
Newly diagnosed Ph+ CML-CP or resistant/intolerant Ph+CML-CP | Pediatrics: 230 mg/m2 PO BID, rounded to the nearest 50 mg dose (to a maximum single dose of 400 mg) | Pediatrics: 400 mg/day  

### VI. Product Availability  
Capsules: 50 mg, 150 mg, 200 mg  

### VII. References  

### Reviews, Revisions, and Approvals  
| Date | P&T Approval Date |  
--- | --- | ---  
Shortened background. Edited safety section to focus on PI contraindications (in algorithm) and warnings/precautions. Combined the 3 algorithms into 1; created Appendices B and C for use in the algorithm – resistance and monitoring parameters per the NCCN CML guidelines; edited approval periods accordingly; removed requests for documentation. | 06.15 | 07.15  
 Converted policy to new template. Removed age and test to detect Philadelphia chromosome requirements; Removed specific questions related to cytogenetic and molecular response and modified to generalized efficacy statement. Added NCCN recommended uses. | 05.16 | 07.16  
CML NCCN: 1) added “myeloid” to “As a single agent for accelerated or myeloid blast phase CML”; 2) “In combination with steroids as primary treatment for CML in lymphoid blast phase” is added; 3) “for relapse” is deleted from “post stem cell transplant therapy;” 4) CML positive for a F317L/V/I/C, T315A, or V299L mutation is added. Maximum dose added. Reasons to discontinue removed. Approval periods are lengthened from 3/6 to 6/12 months. | 06.17 | 07.17
Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
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<tbody>
<tr>
<td>2Q 2018 annual review: no significant changes; policies combined for Medicaid and Commercial; HIM line of business added; added age (not ALL); summarized NCCN and FDA approved uses for improved clarity; added specialist involvement in care; added continuity of care statement; references reviewed and updated.</td>
<td>02.13.18 05.18</td>
</tr>
<tr>
<td>No significant changes: new 50 mg capsule formulation added; pediatric labeled indications added for CML; CML age limit removed; package insert updated.</td>
<td>06.29.18</td>
</tr>
<tr>
<td>2Q 2019 annual review: hematologist added to CML/ALL; references reviewed and updated.</td>
<td>02.19.19 05.19</td>
</tr>
<tr>
<td>2Q 2020 annual review: no significant changes; HIM nonformulary language removed; references reviewed and updated.</td>
<td>02.11.20 05.20</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.

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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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