

## **Clinical Policy: Afatinib (Gilotrif)**

Reference Number: CP.PHAR.298

Effective Date: 01.01.17

Last Review Date: 05.18

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Afatinib (Gilotrif<sup>®</sup>) is a kinase inhibitor.

### **FDA Approved Indication(s)**

Gilotrif is indicated for:

- First-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test.
- Treatment of patients with metastatic squamous NSCLC progressing after platinum-based chemotherapy.

Limitation(s) of Use: The safety and efficacy of Gilotrif have not been established in patients whose tumors have resistant EGFR mutations.

### **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<sup>®</sup> that Gilotrif 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 NSCLC;
2. Prescribed by or in consultation with an oncologist;
3. Age  $\geq$  18 years;
4. Disease is recurrent or metastatic;
5. Member meets one of the following (a or b):
  - a. Disease is positive for any of the following sensitizing EGFR mutations: exon 19 deletion, exon 21 [L858R] substitution, L861Q, G719X, or S768I mutations, as detected by an FDA-approved test;
  - b. Disease is squamous and has progressed after platinum-based chemotherapy (e.g., cisplatin, carboplatin);
6. Dose does not exceed 40 mg per day (1 tablet per day).

##### **Approval duration:**

**Medicaid/Health Insurance Marketplace** – 6 months

**Commercial** – Length of benefit

**B. NCCN-Recommended Off-Label Uses** (off-label) (must meet all):

1. Diagnosis of central nervous system cancer with brain metastases, as supported by NCCN categories 2A;
2. Prescribed by or in consultation with an oncologist;
3. Requested dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Approval duration:**

**Medicaid/Health Insurance Marketplace** – 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**

**A. All Covered Indications** (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Gilotrif 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, new dose does not exceed 40 mg per day (1 tablet per day).

**Approval duration:**

**Medicaid/Health Insurance Marketplace** – 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

NCCN: National Comprehensive Cancer Network  
 NSCLC: non-small cell lung cancer

*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.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Platinum-based chemotherapy regimens (e.g., cisplatin, carboplatin)	Varies	Refer to NCCN Guidelines: Non-Small Cell Lung Cancer for most up-to-date information.

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

*Appendix C: General Information*

- Information on FDA-approved tests for the detection of EGFR mutations in NSCLC is available at: <http://www.fda.gov/CompanionDiagnostics>.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
NSCLC	40 mg PO QD	40 mg/day

**VI. Product Availability**

Tablets: 20 mg, 30 mg, and 40 mg

**VII. References**

- Gilotrif Prescribing Information. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc.; January 2018. Available at: <http://gilotrif.com>. Accessed March 2, 2018.
- Afatinib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at [www.NCCN.org](http://www.NCCN.org). Accessed March 2, 2018.
- Non-small cell lung cancer (Version 3.2018). In: National Comprehensive Cancer Network Guidelines. Available at [www.NCCN.org](http://www.NCCN.org). Accessed March 2, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy	11.16	01.17
Converted to new template. NSCLC: Removed criteria for off-label NCCN use in HER2+ disease as it is a category 2B recommendation. Added criteria for the FDA approved indication of metastatic squamous NSCLC progressing after platinum-based chemotherapy. Added age limit as safety and efficacy have not been established in pediatric patients. Added max dose criteria. Increased approval duration from 3/6 months to 6/12 months per new standard.	08.08.17	11.17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Head and neck cancers: Removed criteria for this off-label NCCN use as it is a category 2B recommendation. Re-auth: Added requirement for positive response to therapy. Removed reasons to discontinue per new safety strategy. Added max dose criteria.		
1Q18 annual review: Policies combined for Centene Medicaid, Commercial and Marketplace lines of business; Initial: Added age requirement as safety and efficacy have not been established in pediatric patients. Removed criteria around specific FDA/NCCN uses that are under the purview of the provider, and added prescriber requirement to ensure appropriate use; Re-auth: Added COC for NSCLC. Removed criteria around use after disease progression on Gilotrif since it is not objective and is under the purview of the provider; References reviewed and updated.	10.30.17	02.18
New indication: updated FDA approved indication and approval criteria to allow coverage for the following uncommon EGFR mutations: L861Q, G719X, and S768I for metastatic NSCLC with sensitizing EGFR mutation; added NCCN 2A recommended off-label use for central nervous system cancer with brain metastases; references reviewed and updated.	02.13.18	05.18

**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.

**For Health Insurance Marketplace members**, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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