RXADVANCE
2 Park Central Drive
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Clinical Policy Title:	nilotinib
Policy Number:	RxA.515
Drug(s) Applied:	Tasigna®
Original Policy Date:	03/06/2020
Last Review Date:	12/07/2020
Line of Business Policy Applies to:	All lines of business

Background

Nilotinib (Tasigna®) is a kinase inhibitor.
It 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.

Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
nilotinib (Tasigna®)	Newly diagnosed Ph+ CML- CP	Adults: 300 mg orally BID	Adults: 600 mg/day
	Resistant/intolerant Ph+ CML-CP or Ph+ CML-AP	Adults: 400 mg orally BID	Adults: 800 mg/day
	Newly diagnosed Ph+ CML- CP or resistant/intolerant Ph+ CML-CP	Pediatrics: 230 mg/m² orally BID, rounded to the nearest 50 mg dose (to a maximum single dose of 400 mg)	Pediatrics: 400 mg/day

Dosage Forms

- Capsule: 50 mg, 150 mg, 200 mg

Clinical Policy

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

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
Commercial: 6 months
Medicaid: 6 months

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).

Approval duration
Commercial: 6 months
Medicaid: 6 months

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).

Approval duration
Commercial: 6 months
Medicaid: 6 months

D. Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes (off-label) (must meet all)**:**

1. Diagnosis of Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Request is for one of the following (a or b):
   a. Preferred treatment for myeloid/lymphoid neoplasms with eosinophilia and ABL1 rearrangement in chronic phase;
   b. Treatment in combination with ALL- or AML-type induction chemotherapy followed by allogeneic HCT (if eligible) for lymphoid, myeloid or mixed lineage neoplasms with eosinophilia and ABL1 rearrangement in blast phase;

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).

Approval duration
Commercial: 6 months
Medicaid: 6 months

II. Continued Therapy Approval

A. All Indications in Section I (must meet all)**:**

1. Currently receiving medication that has been authorized by RxAdvance, or documentation supports that member is currently receiving Tasigna® for all covered indications 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).

Approval duration
Commercial: 12 months
Medicaid: 6 months

III. Appendices

APPENDIX A: Abbreviation/Acronym Key

ALL: acute lymphoblastic leukemia
CML: chronic myeloid leukemia
GIST: gastrointestinal stromal tumor
FDA: Food and Drug Administration
Ph+: positive Philadelphia chromosome

APPENDIX B: Therapeutic Alternatives

Below are suggested therapeutic alternatives based on clinical guidance. Please check drug formulary for preferred agents and utilization management requirements.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
imatinib (Gleevec®)	GIST: 400 mg orally once daily to 800 PO BID	800 mg/day
Sutent® (sunitinib)	GIST: 50 mg orally once daily	50 mg/day
Stivarga® (regorafenib)	GIST: 160 mg orally once daily for the first 21 days of each 28-day cycle	160 mg/day

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

APPENDIX D: General Information

- Not applicable

References

1. Tasigna® Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; June 2020. Available at: http://www.us.tasigna.com/patient/about-ph-cml-treatment.jsp. Accessed August 18 , 2020.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed August 18, 2020.
3. National Comprehensive Cancer Network Guidelines. Chronic Myeloid Leukemia Version 2.2021 Available at www.nccn.org. Accessed October 13, 2020.
4. National Comprehensive Cancer Network Guidelines. Acute Lymphoblastic Leukemia Version 1.2020. Available at www.nccn.org. Accessed August 18, 2020.
5. National Comprehensive Cancer Network Guidelines. Soft Tissue Sarcoma Version 2.2020. Available at www.nccn.org. Accessed August 18, 2020.
6. National Comprehensive Cancer Network Guidelines. Myeloid/ Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase fusion genes Version 3.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/mlne.pdf. Accessed November 13, 2020

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	03/06/2020
Policy was reviewed 1. Policy title table was updated. 2. Line of Business Policy Applies to was update to all lines of business. 3. Added initial therapy criteria for off label indication: Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes. 4. Commercial approval duration was updated for initial and Continued approval criteria from length of benefit to 6 months and 12 months respectively. 5. Continued therapy criteria II.A.1 was rephrased to “Currently receiving medication that has been authorized by RxAdvance…”. 6. APPENDIX B: Therapeutic Alternatives statement was rephrased to “Below are suggested therapeutic alternatives based on clinical guidance. Please check drug formulary for preferred agents and utilization management requirements”. 7. References were reviewed and updated.	11/13/2020	12/7/2020