Clinical Policy Title:	vincristine sulfate liposome injection
Policy Number:	RxA.205
Drug(s) Applied:	Marqibo®
Original Policy Date:	02/07/2020
Last Review Date:	06/10/2021
Line of Business Policy Applies to:	All lines of business

Background

Vincristine sulfate liposome injection (Marqibo®) is a vinca alkaloid. It is indicated for the treatment of adult patients with Philadelphia chromosome-negative (Ph-) acute lymphoblastic leukemia (ALL) in second or greater relapse or whose disease has progressed following two or more anti-leukemia therapies. This indication is based on overall response rate. Clinical benefit such as improvement in overall survival has not been verified.

Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
vincristine sulfate liposome injection (Marqibo®)	ALL	2.25 mg/m^2 intravenously over 1 hour once every 7 days * Should not be administered by any other route	See dosing regimen

Dosage Forms

Marqibo® Kit containing the following:

- Vial: vincristine sulfate injection, USP 5 mg/5 mL (1 mg/mL)
- Vial: sphingomyelin/cholesterol liposome injection 103 mg/mL
- Vial: sodium phosphate injection 355 mg/25 mL (14.2 mg/mL)
- Flotation Ring
- Overlabel for Sodium Phosphate Injection vial containing constituted Marqibo (vinCRIStine sulfate LIPOSOME injection), 5 mg/31 mL (0.16 mg/mL)
- Infusion Bag Label

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. The provision of provider samples does not guarantee coverage under the provisions of the pharmacy benefit administer by RxAdvance. All criteria for initial approval must be met in order to obtain coverage.

I. Initial Approval Criteria

A. Acute Lymphoblastic Leukemia (must meet all):

1. Diagnosis of ALL;

2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. One of the following (a or b):*
   a. For members with Ph- ALL, disease has relapsed ≥ 2 times or has progressed following ≥ 2 anti-leukemia therapies (see Appendix B for examples);
   b. For members with Philadelphia chromosome-positive (Ph+) ALL, disease is refractory to tyrosine kinase inhibitor therapy (e.g., imatinib, Sprycel®, Tasigna®, Bosulif®, Iclusig®) [off-label];
   *Prior authorization may be required.
5. Request meets one of the following (a or b):**
   a. Dose does not exceed 2.25 mg/m^2 every 7 days;
   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
Commercial: 6 months
Medicaid: 6 months

II. Continued Therapy Approval

A. Acute Lymphoblastic Leukemia (must meet all):

1. Member is currently receiving the medication that has been authorized by RxAdvance or member has previously met initial approval criteria or documentation supports that member is currently receiving Marqibo® for a covered indication;
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 2.25 mg/m^2 every 7 days;
   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
Commercial: 6 months
Medicaid: 6 months

III. Appendices

APPENDIX A: Abbreviation/Acronym Key
ALL: Acute Lymphoblastic Leukemia
FDA: Food and Drug Administration
NCCN: National Comprehensive Cancer Network

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	Maximum Dose
Examples of Ph- ALL anti-leukemia therapies		
• CALGB 8811 Larson regimen: daunorubicin, vincristine, prednisone,	Varies	Varies

Drug Name	Dosing Regimen	Maximum Dose
pegaspargase, cyclophosphamide • Single agent therapies such as blinatumomab, inotuzumab, ozogamicin		
Ph+ ALL tyrosine kinase inhibitor therapy		
Gleevec®(imatinib)	600 mg PO once daily	600 mg/day
Sprycel (dasatinib)	140 mg PO once daily	180 mg/day
Tasigna® (nilotinib)	400 mg PO BID	800 mg/day
Bosulif ®(bosutinib)	400-600 mg PO once daily	600 mg/day
Iclusig® (ponatinib)	45 mg PO once daily	45 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):
  - Patients with demyelinating conditions including Charcot-Marie-Tooth syndrome.
  - Intrathecal administration.
  - Hypersensitivity.

- Boxed Warning(s):
  - For intravenous use only – fatal if given by other routes; dosage recommendations differ from vincristine sulfate, verify drug name and dose to avoid overdosage.

APPENDIX D: General Information

- Not applicable

References

1. Marqibo® Prescribing Information. East Windsor, NJ: Acrotech Biopharma LLC; June 2020. Available at: https://marqibo.com/hcp/wp-content/uploads/2019/11/MARQIBO-PI-06-2020-REF-0081.pdf. Accessed March 10, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed March 10, 2021.
3. National Comprehensive Cancer Network. Acute Lymphoblastic Leukemia Version 1. 2021 Available at https://www.nccn.org/professionals/physician_gls/pdf/all.pdf Accessed April 21,, 2021.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	02/07/2020
Policy was reviewed: 1. Clinical Policy Title was updated. 2. Line of Business Policy Applies to was	07/08/2020	09/14/2020

updated to all lines of business. 3. Initial approval criteria were updated to include Commercial and Medicaid approval duration as 6 month. 4. Continued therapy criteria were updated to include commercial and Medicaid approval duration as 6 month. 5. Continued Therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance...". 6. Changed Bosulif dosing from 400-500 mg PO once daily to 400-600 mg PO once daily in Appendix B. 7. References were updated.		
Policy was reviewed: 1. Clinical Policy Title was updated. 2. Background was updated. 3. Continued therapy criteria II.A.1 was rephrased to “Member is currently receiving medication that has been authorized by RxAdvance..” 4. References were reviewed and updated.	03/10/2021	06/10/2021