RXADVANCE
2 Park Central Drive
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Clinical Policy Title:	temsirolimus
Policy Number:	RxA.509
Drug(s) Applied:	Torisel®
Original Policy Date:	03/06/2020
Last Review Date:	12/07/2020
Line of Business Policy Applies to:	All lines of business

Background

Temsirolimus (Torisel®) is a kinase inhibitor. It is indicated for the treatment of advanced renal cell carcinoma (RCC).

Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
temsirolimus (Torisel®)	RCC	25 mg administered as an IV infusion over a 30-60 minute period once a week. Consider 50 mg once a week if concomitant strong CYP3A4 inducer (e.g., dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifampicin, phenobarbital).	50 mg/week

Dosage Forms

- Kit: single-use vial 25 mg/mL temsirolimus; diluent vial 1.8 mL

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. Renal Cell Carcinoma (must meet all)**:**

1. Diagnosis of advanced RCC (i.e., relapsed, metastatic or stage IV disease);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed as a single agent;
5. Member has at least 3 prognostic risk factors (*Appendix D*);
6. Request meets one of the following (a or b): *
   a. Dose does not exceed 25 mg per week (*50 mg per week if member is on concomitant strong CYP3A4 inducer such as dexamethasone, phenytoin, carbamazepine, rifampin,*

rifabutin, rifampicin, phenobarbital);
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
HIM: 6 months

B. Endometrial Carcinoma (off-label) (must meet all)**:**
1. Diagnosis of recurrent, metastatic, and/or high-risk endometrial carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Request meets one of the following (a or b):*
   a. Dose does not exceed 25 mg per week (*50 mg per week if member is on concomitant strong CYP3A4 inducer such as dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifampicin, phenobarbital*).
   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
HIM: 6 months

C. Soft Tissue Sarcoma (off-label) (must meet all)**:**
1. Diagnosis of perivascular epithelioid cell tumor (PEComa), recurrent angiomyolipoma, or lymphangioleiomyomatosis;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Use is as a single agent;
5. Request meets one of the following (a or b): *
   a. Dose does not exceed 25 mg per week (*50 mg per week if member is on concomitant strong CYP3A4 inducer such as dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifampicin, phenobarbital*);
   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
HIM: 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 Torisel® 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 25 mg per week (*50 mg per week if member is on concomitant strong CYP3A4 inducer such as dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifampicin, phenobarbital*);
   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: 12 months
Medicaid: 12 months
HIM: 12 months

III. Appendices

APPENDIX A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
NCCN: National Comprehensive Cancer Network
PEComa: perivascular epithelioid cell tumor
RCC: renal cell carcinoma

APPENDIX B: Therapeutic Alternatives
Not applicable

APPENDIX C: Contraindications/Boxed Warnings
- Contraindication(s):
  - Bilirubin > 1.5 times the upper limit of normal

- Boxed Warning(s):
  - None reported

APPENDIX D: General Information
- At least 3 of the following 6 prognostic risk factors (based on the Torisel® pivotal trial):
  - Interval of less than 1 year from time of RCC diagnosis to start of systemic therapy
  - Karnofsky performance status score of 60 or 70
  - Hemoglobin level below normal (e.g., men < 13.5g/dL, women <12g/dL)
  - Corrected serum calcium level > 10 mg/dL (2.5 mmol per liter)
  - Serum lactate dehydrogenase level > 1.5 times the upper limit of normal
  - More than one metastatic organ site

References

1. Torisel® Prescribing Information. Philadelphia, PA: Pfizer, Inc.; March 2018. Available at http://labeling.pfizer.com/showlabeling.aspx?id=490. Accessed September 8, 2020.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed September 8, 2020.
3. National Comprehensive Cancer Network. Kidney Cancer Version 1.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf. Updated July 15, 2020. Accessed September 8, 2020.
4. National Comprehensive Cancer Network. Soft Tissue Sarcoma Version 2.2020. Available at:

https://www.nccn.org/professionals/physician_gls/pdf/sarcoma.pdf. Updated May 28, 2020. Accessed September 8, 2020.
5. National Comprehensive Cancer Network. Uterine Neoplasms Version 2.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/uterine.pdf. Updated July 24, 2020. Accessed September 8, 2020.
6. Hudes G, Carducci M, Tomczak P, et al. Temsirolimus, interferon alfa, or both for advanced renal-cell carcinoma. N Eng J Med 2007; 356:2271-2281. Accessed September 8, 2020.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy was established	01/2020	03/06/2020
Policy was reviewed: 1. Policy title table was updated: Line of business policy applies was updated to "All lines of business". 2. Terminology "for injection" removed from background and dosing information. 3. Initial approval criteria I.B.1 updated to specify type of endometrial carcinoma. 4. Continued therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance…". 5. References were updated.	09/08/2020	12/07/2020