

## Clinical Policy: Lorlatinib (Lorbrena)

Reference Number: CP.PHAR.406

Effective Date: 12.11.18

Last Review Date: 05.20

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

### Description

Lorlatinib (Lorbrena<sup>®</sup>) is a kinase inhibitor.

### FDA Approved Indication(s)

Lorbrena is indicated for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) whose disease has progressed on

- Crizotinib and at least one other ALK inhibitor for metastatic disease; or
- Alectinib as the first ALK inhibitor therapy for metastatic disease; or
- Ceritinib as the first ALK inhibitor therapy for metastatic disease.

This indication is approved under accelerated approval based on tumor response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

### 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 Lorbrena 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 recurrent, advanced or metastatic NSCLC;
2. Prescribed by or in consultation with an oncologist;
3. Age  $\geq$  18 years;
4. Disease ALK or ROS1 positive;
5. If disease is ALK positive, failure of Alecensa<sup>®</sup>, Alunbrig<sup>®</sup>, Xalkori<sup>®</sup>, or Zykadia<sup>®</sup> unless contraindicated or clinically significant adverse effects are experienced;  
*\*Prior authorization may be required for Alecensa, Alunbrig, Xalkori and Zykadia.*
6. If disease is ROS1 positive, failure of Rozlytrek<sup>™</sup>, Xalkori or Zykadia unless contraindicated or clinically significant adverse effects are experienced;  
*\*Prior authorization may be required for Rozlytrek, Xalkori and Zykadia.*
7. Request meets one of the following (a or b):\*
  - a. Dose does not exceed 100 mg (3 tablets) per day;
  - 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:**

**Medicaid/HIM** – 6 months

**Commercial** – Length of Benefit

**B. 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. Non-Small Cell Lung Cancer** (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Lorbrina for NSCLC 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 100 mg (3 tablets) 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** – 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 policy – 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*

ALK: anaplastic lymphoma kinase

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 and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Alecensa <sup>®</sup> (alectinib)	600 mg PO BID	1,200 mg/day
Alunbrig <sup>®</sup> (brigatinib)	90 mg PO QD for the first 7 days; if tolerated, increase to 180 mg PO QD	180 mg/day
Rozlytrek <sup>®</sup> (entrectinib)	600 mg PO QD	600 mg/day
Zykadia <sup>®</sup> (ceritinib)	450 mg PO QD	450 mg/day
Xalkori <sup>®</sup> (crizotinib)	250 mg PO BID	500 mg/day

*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: Contraindications/Boxed Warnings*

- Contraindication(s): concomitant use with strong CYP3A inducers
- Boxed warning(s): none reported

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
ALK-positive NSCLC	100 mg PO QD	100 mg/day

**VI. Product Availability**

Tablets: 25 mg, 100 mg

**VII. References**

1. Lorbrena Prescribing Information. New York, NY: Pfizer Inc; November 2018. Available at: [www.pfizer.com](http://www.pfizer.com). Accessed February 12, 2020.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: [http://www.nccn.org/professionals/drug\\_compendium](http://www.nccn.org/professionals/drug_compendium). Accessed February 12, 2020.
3. National Comprehensive Cancer Network. Non-Small Cell Lung Cancer Version 2.2020. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/nscl.pdf](https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf). Accessed February 12, 2020.
4. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2019. Available at: <http://www.clinicalpharmacology-ip.com/>. Accessed February 12, 2020.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	12.11.18	02.19
2Q 2019 annual review: no significant changes; references reviewed and updated.	02.19.19	05.19
No significant changes; finalized line of business to apply to HIM.	04.18.19	
2Q 2020 annual review: per NCCN Compendium added Xalkori as a possible redirect option for ALK-positive disease; added Rozlytrek as a	02.12.20	05.20

Reviews, Revisions, and Approvals	Date	P&T Approval Date
possible redirect option for ROS1-positive disease; added quantity limit of 3 tablets to allow for dose adjustments; references reviewed and updated.		

**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.

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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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