Clinical Policy: Enzalutamide (Xtandi)

Reference Number: CP.PHAR.106
Effective Date: 10.12
Last Review Date: 08.18
Line of Business: HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Enzalutamide (Xtandi®) is an androgen receptor inhibitor.

FDA Approved Indication(s)

Xtandi is indicated for the treatment of patients with metastatic castration-resistant prostate cancer (CRPC).

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® that Xtandi is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Prostate Cancer (must meet all)**:**

1. Diagnosis of metastatic CRPC, as evidenced by disease progression despite bilateral orchiectomy or other androgen deprivation therapy (*see Appendix D*);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Dose does not exceed 160 mg per day (4 capsules per day), or 240 mg per day (6 capsules per day) if prescribed concomitantly with a strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, and phenobarbital).

Approval duration: 6 months

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): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Prostate Cancer (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Xtandi for metastatic CRPC 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 160 mg per day (4 capsules per day), or 240 mg per day (6 capsules per day) if prescribed concomitantly with a strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, and phenobarbital).

Approval duration: 12 months

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): 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 – 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
ADT: androgen deprivation therapy
CRPC: castration-resistant prostate cancer
FDA: Food and Drug Administration
LHRH: luteinizing hormone-releasing hormone

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications

- Xtandi is contraindicated for use in pregnant women. Based on animal studies, Xtandi can cause fetal harm and potential loss of pregnancy. Xtandi is not indicated for use in females.

Appendix D: General Information

- Examples of ADT include:
  - Bilateral orchiectomy (surgical castration)
  - Luteinizing hormone-releasing hormone (LHRH) given with or without an anti-androgen:
    - LHRH agonists: Zoladex® (goserelin), Vantas® (histrelin), leuprolide (Lupron Depot®, Eligard®), and Trelstar® (triptorelin)
    - Anti-androgens: bicalutamide (Casodex®), flutamide, nilutamide (Nilandron®), Xtandi® (enzalutamide), Erleada® (apalutamide)
  - LHRH antagonist: Firmagon® (degarelix)

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Metastatic castration-resistant prostate cancer	160 mg (four 40 mg capsules) PO QD	160 mg/day; 240 mg/day if taking a strong CYP3A4 inducer

VI. Product Availability

Capsules: 40 mg

VII. References

1. Xtandi Prescribing Information. Northbrook, IL: Astellas Pharma US.; July 2017. Available at: https://www.xtandi.com/. Accessed May 15, 2018.
2. Enzalutamide. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.NCCN.org. Accessed May 15, 2018.
3. National Comprehensive Cancer Network. Prostate Cancer Version 02.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf. Accessed May 15, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Yes/No decision points were incorrect following disease progression question. Redirected correctly	05.14	
Updated background information and safety and efficacy information Added seizure question to algorithm Removed "through a Centene benefit" from current treatment time	09.14	11.14
Converted policy to bullet format and new template In criteria: eliminated documentation requests, added age requirement, added questions about Xtandi contraindications and expanded reasons to discontinue per PI deleted reference to an appendix in disease progression question, removed question about whether would be used as monotherapy, added initial approval period of 3 months and kept 6 months for continuation approval period	09.15	11.15
Removed question related to Xtandi use as a monotherapy. Approval duration modified to 6 months for initial and 12 months for continued therapy. Added requirement for to max dose. Defined castration resistant prostate cancer. Updated reasons to discontinue per PI.	10.16	11.16
Initial: clarified ADT; added max dose for concomitant use with a strong CYP3A4 inducer for FDA approved used; added NCCN recommended use; re-auth: added efficacy criterion requiring documentation of positive response to therapy. Safety criteria was applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs.	09.17	11.17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2018 annual review: added HIM line of business; specialist requirement was added; off-label use in castration-naïve prostate cancer removed per NCCN guidelines; references reviewed and updated.	05.15.18	08.18

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.