

Clinical Policy: Abemaciclib (Verzenio)

Reference Number: CP.PHAR.355

Effective Date: 10.24.17

Last Review Date: 02.19

Line of Business: Commercial, Medicaid

[Revision Log](#)

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

Description

Abemaciclib (Verzenio®) is an inhibitor of cyclin-dependent kinases 4 and 6 (CDK4/6).

FDA Approved Indication(s)

Verzenio is indicated:

- In combination with fulvestrant for the treatment of women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer with disease progression following endocrine therapy
- As monotherapy for the treatment of adult patients with HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy and prior chemotherapy in the metastatic setting
- In combination with an aromatase inhibitor as initial endocrine-based therapy for the treatment of postmenopausal women with HR-positive, HER2-negative advanced or metastatic breast cancer

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 Verzenio is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Breast Cancer (must meet all):

1. Diagnosis of breast cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age \geq 18 years;
4. Disease has all of the following characteristics (a, b, and c):
 - a. HR-positive (i.e., estrogen receptor (ER) and/or progesterone receptor (PR) positive);
 - b. HER2-negative;
 - c. Advanced (locally recurrent) or metastatic;
5. Verzenio is prescribed in one of the following ways (a, b, or c):
 - a. In combination with fulvestrant after disease progression on an endocrine therapy;
 - b. As a single agent after disease progression on an endocrine therapy and chemotherapy (e.g., docetaxel, gemcitabine);

- c. In combination with an aromatase inhibitor (e.g., letrozole, anastrozole, exemestane), and:
 - i. If male, an agent that suppresses testicular steroidogenesis (e.g., gonadotropin-releasing hormone agonists);
6. Request meets one of the following (a or b):
 - a. Dose does not exceed one of the following (i or ii):
 - i. For combination therapy: 300 mg per day (two 150 mg tablets per day);
 - ii. For monotherapy: 400 mg per day (two 200 mg 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*).

Approval duration:

Medicaid – 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 and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Breast Cancer (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Verzenio for breast cancer and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. Dose is ≥ 100 mg/day;
4. If request is for a dose increase, request meets one of the following (a or b):
 - a. New dose does not exceed one of the following (i or ii):
 - i. For combination therapy: 300 mg per day (two 150 mg tablets per day);
 - ii. For monotherapy: 400 mg per day (two 200 mg tablets per day);
 - b. New dose is supported by practice guideline or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:

Medicaid – 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 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 – CP.CPA.09 for commercial and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

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|--|---|
| CDK: cyclin-dependent kinase | HR: hormone receptor |
| ER: estrogen receptor | NCCN: National Comprehensive Cancer Network |
| FDA: Food and Drug Administration | PR: progesterone receptor |
| HER2: human epidermal growth factor receptor 2 | |

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 for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Endocrine Therapy		
anastrozole (Arimidex®)	1 mg PO QD	1 mg/day
exemestane (Aromasin®)	25 mg PO QD	25 mg/day
Fareston® (toremifene)	60 mg PO QD	60 mg/day
Faslodex® (fulvestrant)	500 mg IM into the buttocks slowly (1 - 2 minutes per injection) as two 5 mL injections, one in each buttock, on days 1, 15, 29 and once monthly thereafter	500 mg/day
letrozole (Femara®)	2.5 mg PO QD	2.5 mg/day
tamoxifen (Nolvadex®, Soltamox®)	20 to 40 mg PO QD	40 mg/day
megestrol acetate	40 mg PO QID	160 mg/day
Chemotherapy		
capecitabine (Xeloda®)	Various	Varies
carboplatin (Paraplatin®)	Various	Varies
cisplatin (Platinol-AQ®)	Various	Varies
cyclophosphamide (Cytosan®)	Various	Varies
docetaxel (Taxotere®)	Various	Varies
doxorubicin (Lipodox®, Doxil®, Adriamycin®)	Various	Varies
epirubicin (Ellence®)	Various	Varies
gemcitabine (Gemzar®)	Various	Varies
Halaven® (eribulin)	Various	Varies
Ixempra® (ixabepilone)	Various	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
paclitaxel (Abraxane [®] , Taxol [®])	Various	Varies
vinorelbine (Navelbine [®])	Various	Varies

Drug names 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

None reported

Appendix D: General Information

- The NCCN recommends that men with breast cancer be treated similarly to postmenopausal women, except that the use of an aromatase inhibitor is ineffective without concomitant suppression of testicular steroidogenesis.
- The NCCN supports use of Verzenio in premenopausal women when used concomitantly with an aromatase inhibitor or fulvestrant. Along with this combination therapy, patients should also be treated with ovarian ablation/suppression. Ovarian ablation can be achieved with surgical oophorectomy or ovarian irradiation. Ovarian suppression can be achieved with luteinizing hormone-releasing hormone agonists (e.g., goserelin, leuprolide).
- For disease progression while on a CDK4/6 inhibitor, there is no data to support retreatment with another CDK4/6 inhibitor-containing regimen.
- Fluoxymesterone and ethinyl estradiol for breast cancer are other endocrine therapies, but they are no longer commercially available.

V. Dosage and Administration

Indication	Dosing Regimen*	Maximum Dose
Breast cancer	In combination with fulvestrant or an aromatase inhibitor: 150 mg PO BID	Combination therapy: 300 mg/day
	As monotherapy: 200 mg PO BID	Monotherapy: 400 mg/day

*If a dose reduction to < 100 mg/day is required, therapy should be discontinued.

VI. Product Availability

Tablet: 50 mg, 100 mg, 150 mg, and 200 mg

VII. References

1. Verzenio Prescribing Information. Indianapolis, IN: Eli Lilly and Company; February 2018. Available at: <http://www.verzenio.com>. Accessed July 6, 2018.
2. Micromedex[®] Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed March 5, 2018.
3. National Comprehensive Cancer Network. Breast Cancer Version 1.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed July 5, 2018.
4. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed July 5, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	10.24.17	11.17
New indication added for initial endocrine therapy in combination with aromatase inhibitor for breast cancer; added specialist requirement.	03.20.18	05.18
4Q 2018 annual review: added requirement for an agent that suppresses testicular steroidogenesis if male and using aromatase inhibitors per NCCN; references reviewed and updated.	07.06.18	02.19

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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