

## Clinical Policy: Venetoclax (Venclexta)

Reference Number: CP.PHAR.129

Effective Date: 07.17.18

Last Review Date: 08.19

Line of Business: Commercial, Medicaid

[Revision Log](#)

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

### Description

Venetoclax (Venclexta®) is a B-cell lymphoma 2 protein (BCL-2) inhibitor.

### FDA Approved Indication(s)

Venclexta is indicated:

- For the treatment of patients with chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL)
- In combination with azacitidine, decitabine, or low-dose cytarabine for the treatment of newly-diagnosed acute myeloid leukemia (AML) in adults who are age 75 years or older, or who have comorbidities that preclude use of intensive induction chemotherapy\*

*\*This indication is approved under accelerated approval based on response rates. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.*

### 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 Venclexta is **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Chronic Lymphocytic Leukemia or Small Lymphocytic Lymphoma (must meet all):

1. Diagnosis of CLL or SLL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Request meets one of the following (a or b):
  - a. Prescribed in combination with Gazyva® as first-line therapy;
  - b. Failure of at least one previous therapy (e.g., Imbruvica®, Campath [not available], high-dose methylprednisolone with Rituxan®) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;  
*\*Prior authorization may be required for these therapies*
5. Request meets one of the following (a or b):
  - a. Dose does not exceed 400 mg (4 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. Mantle Cell Lymphoma (off-label) (must meet all):**

1. Diagnosis of mantle cell lymphoma;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age  $\geq$  18 years;
4. Member has received appropriate prior therapy [induction therapy or chemoimmunotherapy (e.g., RDHAP: Rituxan, dexamethasone, cytarabine, cisplatin; RDHAX: Rituxan, dexamethasone, cytarabine, oxaliplatin; bendamustine plus Rituxan; VR-CAP: bortezomib, Rituxan, cyclophosphamide, doxorubicin, and prednisone)];  
*\*Prior authorization may be required for these therapies*
5. Request meets one of the following (a or b):
  - a. Dose does not exceed 400 mg (4 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

**C. Acute Myeloid Leukemia (must meet all):**

1. Diagnosis of AML;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age  $\geq$  18 years;
4. Member meets one of the following (a or b):
  - a. Age  $\geq$  60 years;
  - b. Medical justification supports inability to use intensive induction chemotherapy (see *Appendix D* for examples);
5. Prescribed in combination with azacitidine, decitabine, or low-dose (20 mg/m<sup>2</sup>) cytarabine;  
*\*Prior authorization may be required for these therapies*
6. Request meets one of the following (a, b, or c):
  - a. In combination with azacitidine or decitabine: Dose does not exceed 400 mg (4 tablets) per day;
  - b. In combination with low-dose cytarabine: Dose does not exceed 600 mg (6 tablets) per day;
  - c. 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

**D. 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. All Indications in Section I (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Venclexta for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For AML, prescribed in combination with azacitidine, decitabine, or low-dose (20 mg/m<sup>2</sup>) cytarabine;
4. If request is for a dose increase, request meets one of the following (a, b, or c):
  - a. CLL, SLL, or in combination with azacitidine or decitabine for AML: New dose does not exceed 400 mg (4 tablets) per day;
  - b. In combination with low-dose cytarabine for AML: New dose does not exceed 600 mg (6 tablets) per day;
  - c. New dose is supported by practice guidelines 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

AML: acute myeloid leukemia

BCL-2: B-cell lymphoma 2 protein

CLL: chronic lymphocytic leukemia

FDA: Food and Drug Administration

NCCN: National Comprehensive Cancer  
Network

SLL: small lymphocytic lymphoma

### 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
Imbruvica (ibrutinib)	Three 140 mg capsules (420 mg) PO QD	420 mg/day
Arzerra <sup>®</sup> (ofatumumab)	Varies	Varies
fludarabine (Fludara <sup>®</sup> , Oforta <sup>®</sup> ), cyclophosphamide (Cytosan <sup>®</sup> , Neosar <sup>®</sup> ) and Rituxan (rituximab) (FCR)	Varies	Varies
fludarabine plus Rituxan (rituximab) (FR)	Varies	Varies
Leukeran <sup>®</sup> (chlorambucil)	Varies	Varies
bendamustine (Treanda <sup>®</sup> , Bekenda <sup>®</sup> ) plus Rituxan (rituximab)	Varies	Varies
pentostatin (Nipent <sup>®</sup> ), cyclophosphamide and Rituxan (rituximab) (PCR)	Varies	Varies
high-dose methylprednisolone with Rituxan (rituximab)	Varies	Varies
Gazyva <sup>®</sup> (obinutuzumab)	Varies	Varies
Leukeran, Rituxan <sup>®</sup>	Varies	Varies

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 of Venclaxta with strong inhibitors of CYP3A at initiation and during ramp-up phase in patients with CLL/SLL
- Boxed warning(s): none reported

*Appendix D: General Information*

- The management of AML is divided into induction and postremission (consolidation) therapy. Induction usually includes intensive chemotherapy (e.g., standard [100-200 mg/m<sup>2</sup>] or high [2 g/m<sup>2</sup>] dose cytarabine, fludarabine), but many adults with AML are unable to undergo intensive chemotherapy due to its toxicities. Some examples of reasons why members may not qualify for intensive induction chemotherapy include, but are not limited to:
  - Baseline Eastern Cooperative Oncology Group (ECOG) performance status of 2-3
  - Severe cardiac comorbidity (e.g., history of congestive heart failure requiring treatment, ejection fraction ≤ 50%, or chronic stable angina)
  - Severe pulmonary comorbidity (e.g., carbon monoxide diffusing capacity [DLCO] ≤ 65% or forced expiratory volume in one second [FEV<sub>1</sub>] ≤ 65%)
  - Moderate hepatic impairment
  - Creatinine clearance < 45 mL/min or baseline creatinine > 1.3 mg/dL
- For AML, the NCCN recommends the use of Venclaxta in patients ≥ 60 years of age who are (category 2A for both):
  - Not candidates for intensive induction chemotherapy
  - Candidates for intensive induction chemotherapy, and have unfavorable cytogenetic/molecular markers/antecedent hematologic disorder/therapy-related AML

## V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CLL and SLL	<p><u>Venclexta 5-week dose ramp-up schedule:</u> 20 mg PO QD for one week followed by 50 mg PO QD for one week, 100 mg PO QD for one week, 200 mg PO QD for one week, then 400 mg PO QD</p> <p><u>Venclexta in combination with Gazyva:</u> On Cycle 1 Day 22, start Venclexta according to the 5-week ramp-up schedule. Continue Venclexta 400 mg QD from Cycle 3 Day 1 until the last day of Cycle 12.</p> <p><u>Venclexta in combination with rituximab:</u> Administer rituximab after the 5-week ramp-up schedule with Venclexta. Continue Venclexta 400 mg QD for 24 months from Cycle 1 Day 1 of rituximab.</p> <p><u>Venclexta as monotherapy:</u> 400 mg PO QD after the patient has completed the 5-week dose ramp-up schedule until disease progression or unacceptable toxicity</p>	400 mg/day
AML	<p>PO QD in combination with azacitidine, decitabine, or low-dose cytarabine:</p> <ul style="list-style-type: none"> <li>• Day 1: 100 mg/day</li> <li>• Day 2: 200 mg/day</li> <li>• Day 3: 400 mg/day</li> <li>• Day 4 and beyond, until disease progression or unacceptable toxicity: <ul style="list-style-type: none"> <li>○ In combination with azacitidine or decitabine: 400 mg/day</li> <li>○ In combination with low-dose cytarabine: 600 mg/day</li> </ul> </li> </ul>	400 mg/day with azacitidine or decitabine; 600 mg/day with cytarabine

## VI. Product Availability

Tablets: 10 mg, 50 mg, 100 mg

## VII. References

1. Venclexta Prescribing Information. North Chicago, IL: AbbVie Inc.; May 2019. Available at: <https://www.venclexta.com>. Accessed May 29, 2019.
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Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created: adapted from CP.CPA.294 (to be retired); added Medicaid, new criteria added for new FDA indication: CLL or SLL, with our without 17p deletion; new policy for Medicaid line of business; added prescriber and age requirements; removed confirmation of the presence of 17p deletion per updated FDA labeling; added continuation of care language for CLL/SLL under continued therapy section; references reviewed and updated.	07.17.18	08.18
4Q 2018 annual review: added off-label coverage criteria for mantle cell lymphoma (NCCN category 2A recommendation); references reviewed and updated.	08.07.18	11.18
Criteria added for new FDA indication: AML; references reviewed and updated.	01.08.19	02.19
Clarified that prior authorization may be required for the agents for prior and combination therapy in I.A.4, 1.B.4, and 1.C.5.	04.22.19	
CLL/SLL criteria updated to allow use as first-line therapy in combination with Gazyva consistent with the expanded FDA indication; references reviewed and updated.	06.11.19	08.19

**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.

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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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