

Clinical Policy: Abiraterone (Zytiga, Yonsa)

Reference Number: CP.PHAR.84

Effective Date: 10.01.11

Last Review Date: 02.20

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

Description

Abiraterone (Zytiga[®], Yonsa[®]) is a selective and irreversible inhibitor of enzyme CYP17.

FDA Approved Indication(s)

Zytiga is indicated in combination with prednisone for the treatment of metastatic castration-resistant prostate cancer and metastatic high-risk castration-sensitive prostate cancer.

Yonsa is indicated in combination with methylprednisolone for the treatment of patients with metastatic castration-resistant prostate 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 Zytiga and Yonsa are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Prostate Cancer (must meet all):

1. Diagnosis of metastatic prostate cancer;
2. Prescribed by or in consultation with an oncologist or urologist;
3. Age \geq 18 years;
4. Member will use a gonadotropin-releasing hormone (GnRH) analog concurrently or has had a bilateral orchiectomy;
5. For Zytiga requests: prescribed in combination with prednisone;
6. For Yonsa requests, both of the following (a and b):
 - a. Prescribed in combination with methylprednisolone;
 - b. Medical justification supports inability to use generic abiraterone (e.g., contraindications to the excipients of generic products);
7. Request meets one of the following (a, b, or c):*
 - a. Zytiga: Dose does not exceed 1,000 mg once daily, or 1,000 mg twice daily if prescribed concomitantly with a strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, and phenobarbital);
 - b. Yonsa: Dose does not exceed 500 mg per day, or 500 mg twice daily if prescribed concomitantly with a strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, and phenobarbital);

- c. 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. Prostate Cancer (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Zytiga or Yonsa for metastatic prostate cancer 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, b, or c):*
 - a. Zytiga: New dose does not exceed 1,000 mg once daily, or 1,000 mg twice daily if prescribed concomitantly with a strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, and phenobarbital);
 - b. Yonsa: New dose does not exceed 500 mg per day, or 500 mg twice daily if prescribed concomitantly with a strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, and phenobarbital);
 - c. 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 policies – 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

ADT: androgen deprivation therapy

CYP17: cytochrome 17 α -hydroxylase/C17,20-lyase

FDA: Food and Drug Administration

LHRH: luteinizing hormone-releasing hormone

Appendix B: Therapeutic Alternatives

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|-------------------------|--|---|
| abiraterone (Zytiga) | 1,000 mg (four 250 mg tablets) PO QD in combination with prednisone 5 mg PO BID (CRPC) or prednisone 5 mg PO QD (CSPC) | 1,000 mg QD; 1,000 mg BID if taking a strong CYP3A4 inducer |

Therapeutic alternatives 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

- Contraindication(s): pregnancy (*Yonsa only*)
- Boxed warning(s): none reported

Appendix D: General Information

- Castration-resistant prostate cancer is prostate cancer that progresses clinically, radiographically, or biochemically despite castrate levels of serum testosterone (< 50 ng/dL). Per the NCCN, androgen deprivation therapy (ADT) should be continued in the setting of CRPC while additional therapies are applied.
- 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)
- Per the NCCN prostate cancer guidelines version 4.2019:
 - For castration-naïve metastatic (M1) prostate cancer: Zytiga + prednisone + ADT has a category 1 recommendation, while Yonsa + methylprednisolone + ADT has a category 2B recommendation.
 - For castration-resistant metastatic (M1) prostate cancer without visceral metastases: Zytiga + prednisone + ADT has a category 1 recommendation, while Yonsa + methylprednisolone + ADT has a category 2A recommendation.
 - For castration-resistant metastatic (M1) prostate cancer with visceral metastases: Both Zytiga + prednisone + ADT and Yonsa + methylprednisolone + ADT have category 2A recommendations.

V. Dosage and Administration

| Drug Name | Indication | Dosing Regimen* | Maximum Dose |
|----------------------|--------------------------------------|---|---|
| Abiraterone (Zytiga) | Castration-resistant prostate cancer | 1,000 mg (four 250 mg tablets or two 500 mg tablets) PO QD in combination with prednisone 5 mg PO BID | 1,000 mg QD; 1,000 mg BID if taking a strong CYP3A4 inducer |
| | Castration-naïve prostate cancer | 1,000 mg (four 250 mg tablets or two 500 mg tablets) PO QD in combination with prednisone 5 mg PO QD | 1,000 mg QD; 1,000 mg BID if taking a strong CYP3A4 inducer |
| Abiraterone (Yonsa) | Castration-resistant prostate cancer | 500 mg (four 125 mg tablets) PO QD in combination with methylprednisolone 4 mg PO BID | 500 mg QD; 500 mg BID if taking a strong CYP3A4 inducer |

*Patients receiving Zytiga or Yonsa should also receive a GnRH analog concurrently or should have had bilateral orchiectomy.

VI. Product Availability

| Drug Name | Availability |
|----------------------|---|
| Abiraterone (Zytiga) | Film-coated tablet: 500 mg Uncoated tablet: 250 mg |
| Abiraterone (Yonsa) | Tablet: 125 mg |

VII. References

1. Zytiga Prescribing Information. Horsham, PA: Janssen Biotech, Inc.; June 2019. Available at: <https://www.zytiga.com/>. Accessed October 7, 2019.
2. Abiraterone acetate. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.NCCN.org. Accessed October 7, 2019.
3. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed February 26, 2019.
4. National Comprehensive Cancer Network. Prostate Cancer Version 4.2019. Available at: https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf. Accessed September 18, 2019.
5. Yonsa Prescribing Information. Cranbury, NU: Sun Pharmaceutical Industries, Inc.; May 2018. Available at: www.yonsarx.com. Accessed October 29, 2019.

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|-------|-------------------|
| Converted policy to bullet format Limited references to PI (updated) and NCCN guidelines (updated); edited narrative accordingly Added abbreviation key, safety appendix; deleted appendix about disease progression (criteria not clearly defined in guidelines) Deleted dose adjustment table and instructions on how to take Zytiga with food | 09.15 | 11.15 |

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|--|----------|-------------------|
| In criteria section, eliminated documentation requests, added age requirement, added question about Zytiga contraindications per PI, kept disease progression question but deleted reference to appendix, removed question about whether would be used with additional treatment, added initial approval period of 3 months and kept 6 months for continuation approval period | | |
| Policy converted to new template. Removed age and prescriber specialty requirements. Added max dose requirement. Updated reasons to discontinue. Approval duration changed to 6 months for initial and 12 months for renewal. | 10.16 | 11.16 |
| Added max dose for concomitant use with a strong CYP3A4 inducer. | 01.17 | |
| Converted to new template. Initial: clarified CRPC. Re-auth: added clarification that Zytiga must be used in combination with; added efficacy requirement of positive response. Safety criteria was applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs. | 09.17 | 11.17 |
| Criteria added for new FDA indication: castration-sensitive prostate cancer. | 03.06.18 | 05.18 |
| 3Q 2018 annual review: added HIM line of business; no significant changes from previously approved corporate policy; references reviewed and updated. | 05.15.18 | 08.18 |
| Changes align with previously approved clinical guidance: Added Yonsa to criteria requiring redirection to generic Zytiga per SDC. | 02.01.19 | |
| 2Q 2019 annual review: no significant changes; references reviewed and updated. | 03.06.19 | 05.19 |
| 1Q 2020 annual review: modified to require that a GnRH analog should always be prescribed concurrently with abiraterone unless member has had a bilateral orchiectomy (regardless of CRPC or CSPC) per FDA labeling and NCCN guidelines; references reviewed and updated. | 10.07.19 | 02.20 |

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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