Clinical Policy: Gefitinib (Iressa)

Reference Number: CP.PHAR.299
Effective Date: 01/17
Last Review Date: 11/16

Coding Implications
Revision Log

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

Description
The intent of the criteria is to ensure that patients follow selection elements established by Centene® clinical policy for gefitinib (Iressa®) tablets for oral use.

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that Iressa 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 or metastatic non-small cell lung cancer (NSCLC);
2. Disease is positive for a sensitizing epidermal growth factor receptor (EGFR) mutation (exon 19 deletion or exon 21 [L858R] substitution) as detected by an FDA approved test:
3. Iressa is prescribed as first-line therapy;
4. Prescribed dose of Iressa does not exceed 250 mg per day *(Note: If Iressa is administered with a strong CYP3A4 inducer [e.g., rifampicin, phenytoin, tricyclic antidepressants], prescribed dose of Iressa does not exceed 500 mg per day).*

Approval duration: 3 months

B. Other diagnoses/indications: Refer to CP.PHAR.57 - Global Biopharm Policy.

II. Continued Approval

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

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. If Iressa is requested after disease progression on Iressa, NSCLC is characterized by any of the following *(off-label NCCN recommended use):*
   i. Asymptomatic disease (without rapid radiologic progression or threatened organ function);
   ii. Symptomatic brain lesions;
   iii. Isolated symptomatic systemic lesions;
3. Member has none of the following reasons to discontinue:
   a. Interstitial lung disease;
   b. Severe hepatic impairment (Child-Pugh C);
   c. Gastrointestinal perforation;
   d. Persistent ulcerative keratitis [ocular].

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy; or
2. Refer to CP.PHAR.57 - Global Biopharm Policy.

Background

Description/Mechanism of Action:

The EGFR is expressed on the cell surface of both normal and cancer cells and plays a role in the processes of cell growth and proliferation. Some EGFR activating mutations (exon 19 deletion or exon 21 point mutation L858R) within NSCLC cells have been identified as contributing to the promotion of tumor cell growth, blocking of apoptosis, increasing the production of angiogenic factors and facilitating the processes of metastasis. Iressa (gefitinib) reversibly inhibits the kinase activity of wild-type and certain activating mutations of EGFR, preventing autophosphorylation of tyrosine residues associated with receptor, therapy inhibiting further downstream signaling and blocking EGFR-dependent proliferation. Gefitinib binding affinity for EGFR exon 19 deletion or exon 21 point mutation L858R mutations is higher than its affinity for the wild-type EGFR. Gefitinib also inhibits IGF and PDGF-mediated signaling at clinically relevant concentrations; inhibition of other tyrosine kinase receptors has not been fully characterized.

Formulations:

Iressa is available as 250 mg tablets for oral administration.

FDA Approved Indications:

Iressa is a tyrosine kinase inhibitor/oral tablet formulation indicated for:

- First-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have EGFR exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test.
  Limitation of use:
  - Safety and efficacy of Iressa have not been established in patients with metastatic NSCLC whole tumors have EGFR mutations other than exon 19 deletions or exon 21 (L858R) substitution mutations.

Appendices

Appendix A: Abbreviation Key

EGFR: epidermal growth factor receptor
IGF: insulin-like growth factor
NSCLC: non-small cell lung cancer
PDGF: platelet-derived growth factor

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J8565	Gefitinib, oral, 250 mg

Reviews, Revisions, and Approvals	Date	Approval Date
New policy.	11/16	01/17

References

1. Iressa Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; July 2015. Available at: http://www.azpicentral.com/iressa/iressa.pdf#page=1. Accessed November 18, 2016.
2. Gefitinib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.NCCN.org. Accessed November 18, 2016.
3. Non-small cell lung cancer (Version 2.2017). In: National Comprehensive Cancer Network Guidelines. Available at NCCN.org. Accessed November 18, 2016.

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.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.