Clinical Policy: Cabazitaxel (Jevtana)

Reference Number: CP.PHAR.316
Effective Date: 02/17
Last Review Date: 02/17

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 cabazitaxel for injection (Jevtana®).

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that Jevtana is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Prostate Cancer (must meet all):

1. Diagnosis of hormone-refractory metastatic prostate cancer;
2. Prescribed in combination with prednisone;
3. History of treatment with a docetaxel-containing regimen;
4. Member has none of the following contraindications:
   a. Neutrophil count ≤ 1,500/mm^3;
   b. History of severe hypersensitivity reaction (e.g., hypotension, bronchospasm, generalized rash/erythema) to cabazitaxel or to other drugs formulated with polysorbate 80;
   c. Severe hepatic impairment (i.e., total bilirubin > 3 times the upper limit of normal [ULN]).

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**Hormone-refractory prostate cancer indicates that disease has progressed despite androgen deprivation therapy (e.g., luteinizing hormone-releasing hormone [LHRH] agonists [e.g., leuprolide, goserelin], first-generation antiandrogens [e.g., nilutamide, flutamide], second-generation antiandrogens [e.g., enzalutamide], LHRH antagonists [e.g., degarelix]).*

Approval duration: 3 months

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

II. Continued Approval

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

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member has none of the following reasons to discontinue:
   a. Disease progression or unacceptable toxicity;
   b. Neutrophil count ≤ 1,500/mm^3;
   c. History of severe hypersensitivity reaction (e.g., hypotension, bronchospasm, generalized rash/erythema) to cabazitaxel or to other drugs formulated with polysorbate 80;

d. Severe hepatic impairment (i.e., total bilirubin > 3 times ULN);
e. Grade 3* (serious) or Grade 4* (life-threatening) peripheral neuropathy.

**Grading is based on the Common Terminology Criteria for Adverse Events (CTCAE).*

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:

Cabazitaxel is a microtubule inhibitor. Cabazitaxel binds to tubulin and promotes its assembly into microtubules while simultaneously inhibiting disassembly. This leads to the stabilization of microtubules, which results in the inhibition of mitotic and interphase cellular functions.

Formulations:

Jevtana is supplied as a kit consisting of the following:
- One single-dose vial of Jevtana injection as a viscous solution of 60 mg/1.5 mL in a clear glass vial.
- One single-dose vial of diluent for Jevtana as a solution of 13% (w/w) ethanol in water for injection in a clear glass vial.

FDA Approved Indications:

Jevtana is a microtubule inhibitor indicated:
- In combination with prednisone for the treatment of patients with hormone-refractory metastatic prostate cancer previously treated with a docetaxel-containing treatment regimen.

Appendices

Appendix A: Abbreviation Key

CTCAE: Common terminology criteria for adverse events
LHRH: Luteinizing hormone-releasing hormone
ULN: Upper limit of normal

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
J9043	Injection, cabazitaxel, 1 mg

Reviews, Revisions, and Approvals	Date	Approval Date
Policy split from CP.PHAR.182 Excellus Oncology.	02/17	02/17

References

1. Jevtana prescribing information. Bridgewater, NJ: Sanofi-aventis U.S., LLC; October 2016. Available at http://products.sanofi.us/jevtana/jevtana.pdf. Accessed January 30, 2017.
2. Cabazitaxel. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at NCCN.org. Accessed January 30, 2017.
3. Prostate cancer (Version 1.2017). In: National Comprehensive Cancer Network Guidelines. Available at NCCN.org. Accessed January 30, 2017.

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.