

Clinical Policy: Olaparib (Lynparza)
Reference Number: HIM.PA.SP5
Effective Date: 08/17
Last Review Date: XX/XX
Line of Business: Health Insurance Marketplace

[Coding Implications](#)
[Revision Log](#)

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

Description

Olaparib (Lynparza[®]) is a poly (ADP-ribose) polymerase (PARP) inhibitor.

FDA approved indication

Lynparza is indicated as monotherapy in patients with deleterious or suspected deleterious germline BRCA-mutated (as detected by an FDA-approved test) advanced ovarian cancer who have been treated with three or more prior lines of chemotherapy.

Policy/Criteria

Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria

I. Initial Approval Criteria

A. Ovarian Cancer (must meet all):

1. Diagnosis of ovarian cancer;
2. Documentation of deleterious or suspected deleterious germline BRCA-mutation;
3. Documentation of treatment with 3 or more chemotherapy regimen;
4. Lynparza will be used as monotherapy;
5. Dose does not exceed 800 mg/day (16 capsules/day).

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to HIM.PHAR.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Ovarian Cancer (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Documentation of positive response to therapy;
3. If request is for a dose increase, new dose does not exceed 800mg/day (16 capsules/day).

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via health plan benefit and documentation supports positive response to therapy.

- Approval duration: Duration of request or 6 months (whichever is less);** or
2. Refer to HIM.PA.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized)

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 policy – HIM.PHAR.21 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ADP: adenosine diphosphate.

BRCA: breast cancer susceptibility gene

FDA: Food and Drug Administration

PARP: poly (ADP-ribose) polymerase

V. References

1. Lynparza Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP. Available at <https://www.lynparza.com/>. Accessed April 2017.
2. National Comprehensive Cancer Network. Ovarian Cancer Version 1.2016. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ovarian.pdf. Accessed March 29, 2017

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	04/17	08/17

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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