Clinical Policy: Eribulin Mesylate (Halaven)

Reference Number: CP.PHAR.318
Effective Date: 03.01.17
Last Review Date: 11.17
Line of Business: Medicaid

Revision Log

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

Description
Eribulin mesylate (Halaven®) is a microtubule dynamics inhibitor.

FDA Approved Indication(s)
Halaven is indicated for the treatment of:

- Metastatic breast cancer
  - Halaven is indicated for the treatment of patients with metastatic breast cancer who have previously received at least two chemotherapeutic regimens for the treatment of metastatic disease. Prior therapy should have included an anthracycline and a taxane in either the adjuvant or metastatic setting.
- Liposarcoma
  - Halaven is indicated for the treatment of patients with unresectable or metastatic liposarcoma who have received a prior anthracycline-containing regimen.

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

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

I. Initial Approval Criteria

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

1. Diagnosis of breast cancer;
2. Age ≥ 18 years;
3. Meets a or b:
   a. FDA approved use:
      i. Prescribed for metastatic disease and member has a positive history for all of the following therapies (a-c):
         a) At least 2 chemotherapeutic regimens in the metastatic setting;
         b) An anthracycline in the adjuvant *(see Appendix B for definition)* or metastatic setting;
         c) A taxane in the adjuvant*(see Appendix B for definition)* or metastatic setting;
   b. Off-label NCCN recommended use:

i. Prescribed for metastatic or recurrent disease in one of the following ways (a or b):
   a) As single-agent therapy for human epidermal growth factor receptor 2 (HER2)-negative disease characterized by (1, 2, or 3):
      1) Presence of symptomatic visceral disease or visceral crisis;
      2) Hormone receptor-negative disease*(see Appendix B for definition)*;
      3) Hormone receptor-positive disease*(see Appendix B for definition)* that is endocrine therapy refractory†;
   b) In combination with trastuzumab for HER2-positive trastuzumab-exposed disease characterized by (1, 2, or 3):
      1) Presence of symptomatic visceral disease or visceral crisis;
      2) Hormone receptor-negative disease*(see Appendix B for definition)*;
      3) Hormone receptor-positive disease*(see Appendix B for definition)* that is endocrine therapy refractory*(see Appendix B for examples of endocrine therapies)*;

4. Request meets one of the following (a or b):
   a. Dose does not exceed 1.4 mg/m^2;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

Approval duration: 6 months

B. Soft Tissue Sarcoma (must meet all)**:**

1. Meets a or b:
   a. FDA approved use (i-iii):
      i. Diagnosis of liposarcoma (soft tissue sarcoma [STS] subtype);
      ii. Disease is unresectable or metastatic;
      iii. Positive history for prior treatment with an anthracycline-containing regimen (e.g., a regimen containing doxorubicin or epirubicin);
   b. Off-label NCCN recommended use (i, ii, or iii):
      i. Angiosarcoma or pleomorphic rhabdomyosarcoma as single-agent palliative therapy;
      ii. Retroperitoneal/intraabdominal STS as single-agent palliative therapy for unresectable or progressive disease;
      iii. Extremity/superficial trunk or head/neck STS as single-agent palliative therapy for stage IV or recurrent disease with disseminated metastases;
2. Age ≥ 18 years;
3. Request meets one of the following (a or b):
   a. Dose does not exceed 1.4 mg/m^2;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

Approval duration: 6 months

C. Other diagnoses/indications

Refer to CP.PHAR.57 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

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

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy (e.g., no disease progression);
3. If request is for a dose increase, request meets one of the following (a or b):
   a. New dose does not exceed 1.4 mg/m^2;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

Approval duration: 12 months

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 CP.PHAR.57 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 – CP.PHAR.57 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
ER: estrogen receptor
HER2: human epidermal growth factor receptor 2
PR: progesterone receptor
STS: soft tissue sarcoma

Appendix B: General Information

- Adjuvant therapy is defined as therapy administered after the main treatment to help decrease the risk of cancer recurring.
- Hormone receptor-negative disease is estrogen receptor [ER] - and progesterone receptor [PR]-negative disease; hormone receptor-positive disease is ER- or PR-positive disease.
- Examples of endocrine therapies include anastrozole, letrozole, exemestane, fulvestrant, tamoxifen, toremifene, megestrol acetate, fluoxymesterone, and ethinyl estradiol.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Breast cancer	1.4 mg/m^2 administered intravenously over 2 to 5 minutes on Days 1 and 8 of a 21-day cycle	1.4 mg/m^2
Soft tissue sarcoma	1.4 mg/m^2 administered intravenously over 2 to 5 minutes on Days 1 and 8 of a 21-day cycle	1.4 mg/m^2

VI. Product Availability

Injection: 1 mg/2 mL, in a single-use vial. One vial per carton.

VII. References

1. Halaven Prescribing Information. Woodcliff Lake, NJ: Eisai, Inc.; October 2016. Available at http://www.halaven.com/pdfs/HALAVEN-Full-Prescribing-Information.pdf. Accessed August 23, 2017.
2. Eribulin mesylate. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at NCCN.org. Accessed August 23, 2017.
3. Breast cancer (Version 2.2017). National Comprehensive Cancer Network Guidelines. Available at NCCN.org. Accessed August 23, 2017.
4. Soft tissue sarcoma (Version 2.2017). National Comprehensive Cancer Network Guidelines. Available at NCCN.org. Accessed August 23, 2017.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.182 Excellus Oncology. NCCN off-label recommended uses added.	02.17	03.17
- Removed requirement for negative history of congenital long QT syndrome and added an age limit for all covered indications, per the PA policy on safety precautions. - Removed coverage of uterine sarcoma, as it is an NCCN 2b-rated recommendation. - Changed approval duration periods from 3/6 months to 6/12 months.	08.23.17	11.17

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.

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.