Clinical Policy: Panitumumab (Vectibix)

Reference Number: CP.PHAR.321
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
Panitumumab (Vectibix®) is an epidermal growth factor receptor (EGFR) antagonist.

FDA Approved Indication(s)
Vectibix is indicated for the treatment of patients with wild-type *RAS* (defined as wild-type in both *KRAS* and *NRAS* as determined by an FDA-approved test for this use) metastatic colorectal cancer (CRC):

- As first-line therapy in combination with FOLFOX
- As monotherapy following disease progression after prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy

Limitation(s) of use: Vectibix is not indicated for the treatment of patients with *RAS*-mutant Metastatic CRC or for whom *RAS* mutation status is unknown.

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 Vectibix is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of CRC;
2. Age ≥ 18 years;
3. Disease is wild-type *RAS* (defined as wild-type in both *KRAS* and *NRAS*);
4. Meets a or b:
   a. FDA approved use (i and ii):
      i. Prescribed for metastatic CRC as first-line therapy in combination with FOLFOX *(see Appendix B for FOLFOX components)*;
      ii. As subsequent therapy as monotherapy after failing fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy;
   b. Off-label NCCN recommended use (i or ii):
      i. Prescribed for unresectable, metastatic, or inoperable CRC (a, b, or c):
         a) As primary therapy;
         b) As subsequent therapy (1, 2, or 3):

1) If not previously treated with cetuximab or panitumumab;
2) Following primary treatment with chemoradiation or local therapy;
3) For unresectable metastatic disease;

ii. Prescribed for rectal cancer in combination with FOLFOX or FOLFIRI *(see Appendix B for FOLFOX and FOLFIRI components)*:
a) As primary therapy for disease characterized as :
1) T3, N0, M0 (Stage IIA) *(see Appendix B for T, N and M definitions)*;
2) Any T, N1-2, M0 (Stage III);
3) T4 (Stage IIB-C, Stage IIIB-C, Stage IV);
4) Locally unresectable or inoperable disease with no metastases if resection is contraindicated following neoadjuvant *(see Appendix B for definition of neoadjuvant)* therapy;

5. Request meets one of the following (a or b):
a. Dose does not exceed 6 mg/kg every 14 days;
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. Other diagnoses/indications
1. 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. Colorectal Cancer (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 6 mg/kg every 14 days;
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

CRC: colorectal cancer
EGFR: epidermal growth factor receptor
FDA: Food and Drug Administration
FOLFIRI: fluorouracil, leucovorin, irinotecan
FOLFOX: fluorouracil, leucovorin, oxaliplatin
KRAS: Kirsten rat sarcoma 2 viral oncogene homologue
mCRC: metastatic colorectal cancer
NRAS: neuroblastoma RAS viral oncogene homologue

Appendix B: General Information

- FOLFIRI is fluorouracil, leucovorin, irinotecan; FOLFOX is fluorouracil, leucovorin, oxaliplatin.
- Neoadjuvant therapy is defined as therapy given as a first step to shrink a tumor before the main therapy.
- The following terms are used to describe tumor stage: T (primary tumor characteristics); N (regional lymph nodes); M (metastatic disease).

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CRC	6 mg/kg every 14 days as an intravenous infusion over 60 minutes (≤ 1000 mg) or 90 minutes (> 1000 mg)	6 mg/kg

VI. Product Availability

Injection: 100 mg/5 mL, 400 mg/20 mL

VII. References

1. Vectibix Prescribing Information. Thousand Oaks, CA: Amgen, Inc.; June 2017. Available at http://pi.amgen.com/~/media/amgen/repositorysites/pi-amgen-com/vectibix/vectibix_pi.ashx. Accessed August 27, 2017.
2. Panitumumab. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at NCCN.org. Accessed August 27, 2017.
3. Colon cancer (Version 2.2017). In: National Comprehensive Cancer Network Guidelines. Available at NCCN.org. Accessed August 27, 2017.
4. Rectal cancer (Version 3.2017). In: National Comprehensive Cancer Network Guidelines. Available at NCCN.org. Accessed August 27, 2017.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.182 Excellus Oncology. NCCN off-label recommended uses added. CRC: NRAS wild type (i.e., not mutated) is added to KRAS wild type as NCCN notes recent evidence indicates that, like KRAS, NRAS mutations are predictive for a lack of benefit to panitumumab. KRAS	01.17	03.17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
and NRAS are members of the RAS human oncogene family. Some NCCN colon cancer off-label recommendations are collapsed and combined into a colorectal cancer section with some rectal cancer indications.		
- Converted to new template, adding age limit and removing safety requirements per the PA Policy on Safety Precautions. - Updated diagnosis requirement to KRAS *and* NRAS to reflect updated FDA indication. - Removed coverage of the following off-label usages which have NCCN 2b recommendations: 1) as adjuvant therapy, and 2) as a single agent in rectal cancer patients who are not appropriate for intensive therapy. - Changed approval durations from 3/6 months to 6/12 months.	08.27.17	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.