Clinical Policy: Nilotinib (Tasigna)

Reference Number: CP.PHAR.76
Effective Date: 09/11
Last Review Date: 07/17

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 nilotinib (Tasigna®) capsules.

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

I. Initial Approval Criteria

A. Chronic Myeloid Leukemia (must meet all):

1. Diagnosis of chronic myeloid leukemia (CML);
2. CML is Philadelphia chromosome positive (Ph+) or BCR-ABL1 positive;
3. Member meets a or b:
   a. FDA approved use (i or ii):
      i. Newly diagnosed CML in chronic phase;
      ii. Chronic or accelerated phase CML with history of resistance or intolerance to imatinib;
   b. Off-label NCCN recommended use (any of the following):
      i. Chronic phase CML with history of resistance or intolerance to dasatinib;
      ii. As a single agent for accelerated or myeloid blast phase CML;
      iii. In combination with steroids as primary treatment for lymphoid blast phase CML;
      iv. In combination with induction chemotherapy followed by stem cell transplant for blast phase CML;
      v. Post stem cell transplant;
      vi. If positive for a F317L/V/I/C, T315A, or V299L mutation.
4. Dose does not exceed 800 mg/day;
5. Member has none of the following contraindications:
   a. Uncorrected hypokalemia;
   b. Uncorrected hypomagnesemia;
   c. Long QT syndrome.

Approval duration: 6 months

B. Other diagnoses/indications:

1. Additional NCCN recommended uses meeting NCCN categories 1, 2a or 2b are covered for the following indications per the CP.PHAR.57 Global Biopharm Policy:
   a. Acute lymphoblastic leukemia (ALL);
   b. Gastrointestinal stromal tumor (GIST).

II. Continued Approval

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

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy.

Approval duration: 12 months

B. Other diagnoses/indications (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 - Global Biopharm Policy.

Background

Description/Mechanism of Action:
Nilotinib belongs to a pharmacologic class of drugs known as kinase inhibitors. It is an inhibitor of the BCR-ABL kinase. Nilotinib binds to and stabilizes the inactive conformation of the kinase domain of ABL protein. In vitro, nilotinib inhibited BCR-ABL mediated proliferation of murine leukemic cell lines and human cell lines derived from patients with Philadelphia chromosome positive CML.

Formulations:
Capsule, oral administration
Tasigna: 150 mg, 200 mg

FDA Approved Indications:
Tasigna is a kinase inhibitor/oral capsule formulation indicated for:

- Treatment of adult patients with newly diagnosed Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase. The effectiveness of Tasigna is based on major molecular response and cytogenetic response rates.
- Treatment of chronic phase and accelerated phase Philadelphia chromosome positive chronic myelogenous leukemia (Ph+ CML) in adult patients resistant or intolerant to prior therapy that included imatinib. The effectiveness of Tasigna is based on hematologic and cytogenetic response rates.

Appendices

Appendix A: Abbreviation Key
ALL: acute lymphoblastic leukemia
CML: chronic myeloid leukemia
Ph+: positive Philadelphia chromosome
GIST: gastrointestinal stromal tumor

Reviews, Revisions, and Approvals	Date	Approval Date
Added new assessment questions at 6 months of therapy	08/13	08/13

Reviews, Revisions, and Approvals	Date	Approval Date
Standardized language related to continuing therapy, efficacy, and toxicity Added question related to loss of hematologic or cytogenetic response Shortened the duration of approval from 12 months to 6 months		
Added clinical information, dosing strategies and monitoring parameters Added Table 1. efficacy data and Table 2 Hyperbilirubinemia criteria Figure 1 Algorithm: removed counseling with food, ECG monitoring, moved diagnosis question up Figure 2 Algorithm: shortened initial duration of approval up to 4 months and duration periods for current treatment Figure 3 Algorithm: shortened initial duration of approval up to 4 months and duration periods for current treatment	07/14	08/14
Shortened background. Edited safety section to focus on PI contraindications (in algorithm) and warnings/precautions. Combined the 3 algorithms into 1; created Appendices B and C for use in the algorithm – resistance and monitoring parameters per the NCCN CML guidelines; edited approval periods accordingly; removed requests for documentation.	06/15	07/15
Converted policy to new template. Removed age and test to detect Philadelphia chromosome requirements; Removed specific questions related to cytogenetic and molecular response and modified to generalized efficacy statement. Added NCCN recommended uses.	05/16	07/16
CML NCCN: 1) added “myeloid” to “As a single agent for accelerated or myeloid blast phase CML”; 2) “In combination with steroids as primary treatment for CML in lymphoid blast phase” is added; 3) “for relapse” is deleted from “post stem cell transplant therapy;” 4) CML positive for a F317L/V/I/C, T315A, or V299L mutation is added. Maximum dose added. Reasons to discontinue removed. Approval periods are lengthened from 3/6 to 6/12 months.	06/17	07/17

References

1. Tasigna Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; February 2017. Available at: http://www.us.tasigna.com/patient/about-ph-cml-treatment.jsp. Accessed June 15, 2017.
2. Nilotinib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed June 15, 2017.
3. Chronic myelogenous leukemia (Version 2.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed June 19, 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.