Clinical Policy: Pemigatinib (Pemazyre)

Reference Number: CP.PHAR.496
Effective Date: 09.01.20
Last Review Date: 05.22
Line of Business: Commercial, HIM, Medicaid Revision Log

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

Description

Pemigatinib (Pemazyre™) is a small molecule kinase inhibitor that inhibits fibroblast growth factor receptor (FGFR).

FDA Approved Indication(s)

Pemazyre is indicated for the treatment of adults with previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test.

This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

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

I. Initial Approval Criteria

A. Cholangiocarcinoma (must meet all)**:**

1. Diagnosis of unresectable locally advanced or metastatic cholangiocarcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Documentation of FGFR2 fusion or rearrangement;
5. Member has not previously received a selective FGFR inhibitor (e.g., Stivarga®);
6. Failure of at least one previous systemic cancer therapy (*see Appendix B*);
7. Request meets one of the following (a or b):*
   a. Dose does not exceed 13.5 mg (1 tablet) per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months
Commercial – 12 months or duration of request, whichever is less

B. Myeloid/Lymphoid Neoplasms with Eosinophilia (off-label) (must meet all)**:**
1. Diagnosis of myeloid/lymphoid neoplasms with eosinophilia;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Confirmation of FGFR1 rearrangement;
5. Member is unable to enroll in a Pemazyre clinical trial;
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 13.5 mg (1 tablet) per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months
Commercial – 12 months or duration of request, whichever is less

C. Other diagnoses/indications
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Pemazyre for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 13.5 mg (1 tablet) per day;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

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 the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

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 policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
FGFR: fibroblast growth factor receptor

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
gemcitabine (Gemzar®) + cisplatin	Gemcitabine 1000 mg/m^2 IV in combination with cisplatin 25 mg/m^2 IV, both on days 1 and 8 every 21 days for 8 cycles	Varies
5-fluorouracil + oxaliplatin	Varies	Varies
5-fluorouracil + cisplatin	Varies	Varies
capecitabine (Xeloda®) + cisplatin	Varies	Varies
capecitabine (Xeloda®) + oxaliplatin	Varies	Varies
gemcitabine + Abraxane®	Varies	Varies
gemcitabine (Gemzar®) + capecitabine (Xeloda®)	Varies	Varies
gemcitabine (Gemzar®) + oxaliplatin	Varies	Varies
5-fluorouracil	Varies	Varies
capecitabine (Xeloda®)	Varies	Varies
gemcitabine (Gemzar®)	Varies	Varies
FOLFOX (5-fluorouracil, leucovorin, oxaliplatin)	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Cholangiocarcinoma	13.5 mg PO QD for 14 days followed by 7 days off therapy, in 21-day cycles	13.5 mg/day

VI. Product Availability

Tablets: 4.5 mg, 9 mg, 13.5 mg

VII. References

1. Pemazyre Prescribing Information. Wilmington, DE: Incyte Corporation; February 2021. Available at: https://www.pemazyre.com/pdf/prescribing-information.pdf. Accessed March 25, 2021.
2. Abou-Alfa GK, Sahai V, Hollebecque A, et al. Pemigatinib for previously treated, locally advanced or metastatic cholangiocarcinoma: a multicentre, open-label, phase 2 study. Lancet Oncol 2020 Marc 20;S1470-2045(20)30109-1.
3. Ghassan A, Sahai V, Hollebecque A, et al. Pemigatinib for previously treated, locally advanced or metastatic cholangiocarcinoma: a multicentre, open-label, phase 2 study. Lancet Oncol 2020 May; 21(5):671-684.
4. National Comprehensive Cancer Network. Hepatobiliary Cancers v1.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/hepatobiliary.pdf. Accessed March 25, 2021.
5. National Comprehensive Cancer Network. Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes v3.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/mlne.pdf. Accessed March 25, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	05.26.20	08.20
3Q 2021 annual review: added NCCN compendium supported off-label use in myeloid/lymphoid neoplasms with eosinophilia and tyrosine kinase fusion genes; for cholangiocarcinoma remove language allowing for first-line use if other alternatives are not suitable, as Pemazyre is only indicated as second-line therapy; modified HIM.PHAR.21 to reference HIM.PA.154; references reviewed and updated.	03.25.21	08.21
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less	01.20.22	05.22

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.