

Clinical Policy: Brigatinib (Alunbrig)

Reference Number: CP.PHAR.342

Effective Date: 07.17.17

Last Review Date: 05.18

Line of Business: Commercial; Medicaid

[Revision Log](#)

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

Description

Brigatinib (Alunbrig[™]) is a kinase inhibitor.

FDA Approved Indication(s)

Alunbrig is indicated for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) who have progressed on or are intolerant to crizotinib.

This indication is approved under accelerated approval based on tumor 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.

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

I. Initial Approval Criteria

A. Non-Small Cell Lung Cancer (must meet all):

1. Diagnosis of NSCLC;
2. Prescribed by or in consultation with an oncologist;
3. Age \geq 18 years;
4. Disease is characterized as both of the following (a and b):
 - a. Recurrent or metastatic;
 - b. ALK-positive;
5. Failure of crizotinib (Xalkori)* or ceritinib (Zykadia)* unless contraindicated or clinically significant adverse effects are experienced;

**Prior authorization is (or may be) required*

6. Dose does not exceed 180 mg/day.

Approval duration:

Medicaid - 6 months

Commercial – Length of Benefit

B. Other diagnoses/indications

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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 and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Non-Small Cell Lung Cancer (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Alunbrig for NSCLC 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, new dose does not exceed 180 mg/day.

Approval duration:

Medicaid - 6 months

Commercial – Length of Benefit

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 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 policy – CP.CPA.09 for commercial and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALK: anaplastic lymphoma kinase

FDA: Food and Drug Administration

NCCN: National Comprehensive Cancer Network

NSCLC: non-small cell lung cancer

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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Xalkori® (crizotinib)	ALK-positive NSCLC 250 mg PO BID	500 mg/day

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Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Zykadia [®] (ceritinib)	ALK-positive NSCLC 750 mg PO QD	1500 mg/day

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.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
ALK-positive NSCLC	90 mg orally once daily for the first 7 days; if tolerated, increase to 180 mg orally once daily	180 mg/day

VI. Product Availability

Tablets: 30 mg, 90 mg, 180 mg

VII. References

1. Alunbrig Prescribing Information. Cambridge, MA: ARIAD Pharmaceuticals, Inc.; April 2017. Available at: www.alunbrig.com. Accessed January 2018.
2. National Comprehensive Cancer Network. Non-Small Cell Lung Cancer Version 2.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed January 2018.
3. Brigatinib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed January 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	05.17	07.17
2Q 2018 annual review: no significant changes; combined policies for Medicaid and Commercial lines of business; added age; approval duration for commercial changed to length of benefit; summarized NCCN and FDA approved uses for improved clarity; added specialist involvement in care; added continuity of care statement; references reviewed and updated.	02.13.18	05.18

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

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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.

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