Clinical Policy: Abemaciclib (Verzenio)

Reference Number: PA.CP.PHAR.355
Effective Date: 10.24.17
Last Review Date: 01.19

Revision Log

Description
Abemaciclib (Verzenio®) is an inhibitor of cyclin-dependent kinases 4 and 6 (CDK4 and CDK6).

FDA Approved Indication(s)
Verzenio is indicated:

- In combination with fulvestrant for the treatment of women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer with disease progression following endocrine therapy.
- As monotherapy for the treatment of adult patients with HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy and prior chemotherapy in the metastatic setting.
- In combination with an aromatase inhibitor as initial endocrine-based therapy for the treatment of postmenopausal women with HR-positive, HER2-negative advanced or metastatic breast cancer.

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 PA Health & Wellness that Verzenio 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. Prescribed by or in consultation with an oncologist;
3. Disease has all of the following characteristics (a, b, and c):
   a. HR-positive (i.e., estrogen receptor (ER) and/or progesterone receptor (PR) positive);
   b. HER2-negative;
   c. Advanced (locally recurrent) or metastatic;
4. Age ≥ 18 years;
5. Verzenio is prescribed in one of the following ways (a, b, or c):
   a. In combination with fulvestrant after disease progression on an endocrine therapy;
   b. As a single agent after disease progression on an endocrine therapy and chemotherapy (e.g., docetaxel, gemcitabine);
   c. In combination with an aromatase inhibitor (e.g., letrozole, anastrozole, exemestane), and:

      i. If male, an agent that suppresses testicular steroidogenesis (e.g., gonadotropin-releasing hormone agonists);

6. Request meets one of the following (a or b):
    a. Dose does not exceed one of the following (i or ii):
        i. For combination therapy: 300 mg/day (two 150 mg tablets/day)
        ii. For monotherapy: 400 mg/day (two 200 mg tablets/day).
    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 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): PA.CP.PMN.53 for Medicaid.

II. Continued Therapy

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

1. Currently receiving medication via PA Health &Wellness benefit or member has met all initial approval criteria or the Continuity of Care Policy (PA.LTSS.PHAR.01) applies;
2. Member is responding positively to therapy;
3. Dose is ≥ 100 mg/day;
4. If request is for a dose increase, new dose does not exceed one of the following (a or b):
    a. New dose does not exceed one of the following (i or ii):
        i. For combination therapy: 300 mg/day (two 150 mg tablets/day);
        ii. For monotherapy: 400 mg/day (two 200 mg tablets/day).
    b. New dose is supported by practice guideline 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 PA Health &Wellness benefit or member has met all initial approval criteria or the Continuity of Care Policy (PA.LTSS.PHAR.01) applies;
   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): PA.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 – PA.CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CDK: cyclin-dependent kinase
ER: estrogen receptor
FDA: Food and Drug Administration

HER2: human epidermal growth factor receptor 2
HR: hormone receptor
NCCN: National Comprehensive Cancer Network
PR: progesterone 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
Endocrine Therapy		
anastrozole (Arimidex®)	1 mg PO QD	1 mg/day
exemestane (Aromasin®)	25 mg PO QD	25 mg/day
Fareston® (toremifene)	60 mg PO QD	60 mg/day
Faslodex® (fulvestrant)	500 mg IM into the buttocks slowly (1 - 2 minutes per injection) as two 5 mL injections, one in each buttock, on days 1, 15, 29 and once monthly thereafter	500 mg/day
letrozole (Femara®)	2.5 mg PO QD	2.5 mg/day
tamoxifen (Nolvadex®, Soltamox®)	20 to 40 mg PO QD	40 mg/day
megestrol acetate	40 mg PO QID	160 mg/day
Chemotherapy		
capecitabine (Xeloda®)	Various	Varies
carboplatin (Paraplatin®)	Various	Varies
cisplatin (Platinol-AQ®)	Various	Varies
cyclophosphamide (Cytoxan®)	Various	Varies
docetaxel (Taxotere®)	Various	Varies
doxorubicin (Lipodox®, Doxil®, Adriamycin®)	Various	Varies
epirubicin (Ellence®)	Various	Varies
gemcitabine (Gemzar®)	Various	Varies
Halaven® (eribulin)	Various	Varies
Ixempra® (ixabepilone)	Various	Varies
paclitaxel (Abraxane®, Taxol®)	Various	Varies
vinorelbine (Navelbine®)	Various	Varies

Drug names 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

Appendix D: General Information

- The NCCN recommends that men with breast cancer be treated similarly to postmenopausal women, except that the use of an aromatase inhibitor is ineffective without concomitant suppression of testicular steroidogenesis.
- The NCCN supports use of Verzenio in premenopausal women when used concomitantly with an aromatase inhibitor or fulvestrant. Along with this combination therapy, patients should also be treated with ovarian ablation/suppression. Ovarian ablation can be achieved with surgical oophorectomy or ovarian irradiation. Ovarian suppression can be achieved with luteinizing hormone-releasing hormone agonists (e.g., goserelin, leuprolide).
- For disease progression while on a CDK4/6 inhibitor, there is no data to support retreatment with another CDK4/6 inhibitor-containing regimen.
- Fluoxymesterone and ethinyl estradiol for breast cancer are other endocrine therapies, but they are no longer commercially available.

V. Dosage and Administration

Indication	Dosing Regimen*	Maximum Dose
Breast cancer	In combination with fulvestrant or an aromatase inhibitor: 150 mg PO BID As monotherapy: 200 mg PO BID	Combination therapy: 300 mg/day Monotherapy: 400 mg/day

**If a dose reduction to < 100 mg/day is required, therapy should be discontinued.*

VI. Product Availability

Tablet: 50 mg, 100 mg, 150 mg, and 200 mg

VII. References

1. Verzenio Prescribing Information. Indianapolis, IN: Eli Lilly and Company; February 2018. Available at: http://www.verzenio.com. Accessed July 6, 2018.
2. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed March 5, 2018.
3. National Comprehensive Cancer Network. Breast Cancer Version 1.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed July 5, 2018.
4. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed July 5, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2019 annual review: added requirement for an agent that suppresses testicular steroidogenesis if male and using aromatase inhibitors per NCCN; references reviewed and updated.	01/19	