Clinical Policy: Acalabrutinib (Calquence)

Reference Number: PA.CP.PHAR.366
Effective Date: 12.05.17
Last Review Date: 01.19

Revision Log

Description
Acalabrutinib (Calquence®) is a Bruton tyrosine kinase inhibitor.

FDA Approved Indication(s)
Calquence is indicated for the treatment of adult patients with mantle cell lymphoma (MCL) who have received at least one prior therapy.

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

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 PA Health & Wellness that Calquence is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Mantle Cell Lymphoma (must meet all)**:**

1. Diagnosis of MCL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Previously received at least one prior therapy (*see Appendix B*);
5. Request meets one of the following (a or b):
   a. Dose does not exceed 400 mg (4 capsules) per 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. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (off-label) (must meet all)**:**

1. Diagnosis of CLL or SLL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Disease is relapsed or refractory;
5. Previously received at least one prior therapy (*see Appendix B*);
6. If refractory to Imbruvica®, member does not have BTK C481S mutations;
7. Request meets one of the following (a or b):
   a. Dose does not exceed 400 mg (4 capsules) per 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

C. Other diagnoses/indications
1. Refer to PA.CP.PMN.53.

II. Continued Therapy

A. All Indications in Section I (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. If request is for a dose increase, request meets one of the following (a or b):
   a. New dose does not exceed 400 mg (4 capsules) 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*).

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 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
BTK: Bruton tyrosine kinase
FDA: Food and Drug Administration
MCL: mantle cell lymphoma

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
First-Line Treatment Regimens for MCL		

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
CALGB (rituximab + methotrexate + cyclophosphosphamide, doxorubicin, vincristine, prednisone; etoposide, cytarabine, rituximab; carmustine, etoposide, cyclophosphamide/autologous stem cell rescue; rituximab)	Varies	Varies
HyperCVAD (cyclophosphamide, vincristine, doxorubicin, dexamethasone/methotrexate/ cytarabine) + rituximab	Varies	Varies
NORDIC (rituximab + cyclophosphamide, vincristine, doxorubicin, prednisone/rituximab + cytarabine)	Varies	Varies
RCHOP/RDHAP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone)/(rituximab, dexamethasone, cisplatin, cytarabine)	Varies	Varies
RDHAP (rituximab, dexamethasone, cisplatin, cytarabine)	Varies	Varies
RCHOP/RICE (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone)/(rituximab, ifosfamide, carboplatin, etoposide)	Varies	Varies
Bendeka® (bendamustine) + Rituxan® (rituximab)	Varies	Varies
VR-CAP (bortezomib, rituximab, cyclophosphamide, doxorubicin, prednisone)	Varies	Varies
CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) + Rituxan® (rituximab)	Varies	Varies
Revlimid® (lenalidomide) + Rituxan® (rituximab)	Varies	Varies
First-Line Treatment Regimens for CLL/SLL		
Without del(17p)/TP53 mutation		
Leukeran® (chlorambucil) + Gazyva® (obinutuzumab)	Varies	Varies
Imbruvica® (ibrutinib)*	Varies	Varies
Leukeran® (chlorambucil) + Arzerra® (ofatumumab)	Varies	Varies
Leukeran® (chlorambucil) + Rituxan® (rituximab)	Varies	Varies
bendamustine (Bendeka®, Treanda®)+ CD20 monoclonal antibody (e.g., rituximab, ofatumumab, obinutuzumab)	Varies	Varies
FR/FCR (fludarabine, rituximab ± cyclophosphamide)	Varies	Varies
With del(17p)/TP53 mutation		
Campath® (alemutuzumab) ± Rituxan® (rituximab)	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
High-dose methylprednisolone + Rituxan® (rituximab)	Varies	Varies
Gazyva® (obinutuzumab)	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

Appendix D: General Information
- Per NCCN: Due to lack of activity, Calquence should not be used for ibrutinib-refractory CLL cells with BTK C481S mutations. Calquence can however be used in cases of ibrutinib intolerance.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Mantle cell lymphoma	100 mg PO BID	400 mg/day

VI. Product Availability
Capsule: 100 mg

VII. References
1. Calquence Prescribing Information. Wilmington, DE; AstraZeneca Pharmaceuticals LP: November 2017. Available at www.calquence.com. Accessed October 30, 2018.
2. National Comprehensive Cancer Network. B-cell Lymphomas Version 5.2018. Available at https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed October 30, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2019 annual review: per 2018 GOLD and 2003 ATS guidelines, corrected FEV_1 range to include 65% without requiring demonstration of rapid decline in lung function in FEV_1 of > 100 mL/year; references reviewed and updated.	01/19	