Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review. Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: 11/01/2020**
Policy Number: PA.CP.PHAR.324	**Effective Date: 01/2020** **Revision Date: 10/2020**
Policy Name: Temsirolimus (Torisel)	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ✓ **Revised Policy***
- ☐ **Annual Review - No Revisions**
- ☐ **Statewide PDL -** *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

Added age limit; updated appendices; references reviewed and updated.

Name of Authorized Individual (Please type or print): **Auren Weinberg, MD**	**Signature of Authorized Individual:** 

Clinical Policy: Temsirolimus (Torisel)

Reference Number: PA.CP.PHAR.324
Effective Date: 01/18
Last Review Date: 10/30/2019

Coding Implications
Revision Log

Description
Temsirolimus for injection (Torisel®) is a kinase inhibitor.

FDA Approved Indication(s)
Torisel is indicated for the treatment of advanced renal cell carcinoma (RCC).

Policy/Criteria
It is the policy of Pennsylvania Health and Wellness ® that Torisel is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Renal Cell Carcinoma (must meet all):
1. Diagnosis of advanced RCC (i.e., relapsed, metastatic or stage IV disease);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Use is as a single agent;
5. Member has at least 3 prognostic risk factors (*Appendix D*);
6. Request meets one of the following (a or b):
   a. Dose does not exceed 25 mg per week (*50 mg per week if member is on concomitant strong CYP3A4 inducer such as dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifampicin, phenobarbital*);
   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. Endometrial Carcinoma (off-label) (must meet all)**:**
1. Diagnosis of endometrial carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Request meets one of the following (a or b):
   a. Dose does not exceed 25 mg per week (*50 mg per week if member is on concomitant strong CYP3A4 inducer such as dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifampicin, phenobarbital*);
   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. Soft Tissue Sarcoma (off-label) (must meet all)**:**
1. Diagnosis of perivascular epithelioid cell tumor (PEComa), recurrent angiomyolipoma, or lymphangioleiomyomatosis;
2. Prescribed by or in consultation with an oncologist;

3. Age ≥ 18 years;
4. Use is as a single agent;
5. Request meets one of the following (a or b):
   a. Dose does not exceed 25 mg per week (*50 mg per week if member is on concomitant strong CYP3A4 inducer such as dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifampicin, phenobarbital*);
   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

D. Other diagnoses/indications: Refer to PA.CP.PMN.53

II. Continued Approval

A. All Indications (must meet all)**:**

1. Currently receiving medication via Pennsylvania Health and Wellness benefit or member has previously met all initial approval criteria; or the Continuity of Care policy (PA.LTSS.PHAR.01) applies;
2. Member is responding positively to therapy;
3. Request meets one of the following (a or b):
   a. Dose does not exceed 25 mg per week (*50 mg per week if member is on concomitant strong CYP3A4 inducer such as dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifampicin, phenobarbital*);
   b. 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 Pennsylvania Health and Wellness benefit and documentation supports positive response to therapy; or the Continuity of Care policy (PA.LTSS.PHAR.01) applies; or
2. Refer to PA.CP.PMN.53

III. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
NCCN: National Comprehensive Cancer Network
PEComa: perivascular epithelioid cell tumor
RCC: renal cell carcinoma

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Black Box Warnings

- Contraindication(s): bilirubin >1.5 times the upper limit of normal
- Boxed warning(s): none reported

Appendix D: General Information

- At least 3 of the following 6 prognostic risk factors (based on the Torisel pivotal trial):
  - Interval of less than 1 year from time of RCC diagnosis to start of systemic therapy
  - Karnofsky performance status score of 60 or 70
  - Hemoglobin level below normal (e.g., men < 13.5g/dL, women <12g/dL)
  - Corrected serum calcium level > 10 mg/dL (2.5 mmol per liter)
  - Serum lactate dehydrogenase level > 1.5 times the upper limit of normal
  - More than one metastatic organ site

IV. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
RCC	25 mg administered as an IV infusion over a 30-60 minute period once a week. Consider 50 mg once a week if concomitant strong CYP3A4 inducer (e.g., dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifampicin, phenobarbital).	50 mg/week

V. Product Availability

Kit: single-use vial 25 mg/mL temsirolimus; diluent vial 1.8 mL

VI. References

1. Torisel Prescribing Information. Philadelphia, PA: Pfizer, Inc.; March 2018. Available at http://labeling.pfizer.com/showlabeling.aspx?id=490. Accessed August 10, 2020.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed August 10, 2020.
3. National Comprehensive Cancer Network. Kidney Cancer Version 1.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf. Accessed August 10, 2020.
4. National Comprehensive Cancer Network. Soft Tissue Sarcoma Version 2.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/sarcoma.pdf. Accessed August 10, 2020.
5. National Comprehensive Cancer Network. Uterine Neoplasms Version 2.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/uterine.pdf. Accessed August 10, 2020.
6. Hudes G, Carducci M, Tomczak P, et al. Temsirolimus, interferon alfa, or both for advanced renal-cell carcinoma. N Eng J Med 2007; 356:2271-2281.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9330	Injection, temsirolimus, 1 mg

Reviews, Revisions, and Approvals	Date	Approval Date
4Q 2018 annual review: no significant changes; specialist involvement in care and continuation of care added; references reviewed and updated.	08/18	
4Q 2019 annual review: No changes per Statewide PDL implementation 01-01-2020	10/30/19	
4Q 2020 annual review: Added age limit; updated appendices; references reviewed and updated.	8/20	11/20