Clinical Policy: Paclitaxel, Protein-Bound (Abraxane)

Reference Number: PA.CP.PHAR.176
Effective Date: 01/2018
Last Review Date: 04/2023

Coding Implications
Revision Log

Description
Protein-bound paclitaxel (Abraxane®) is microtubule inhibitor.

FDA approved indication
Abraxane is indicated for the treatment of:

- Metastatic breast cancer, after failure of combination chemotherapy for metastatic disease or relapse within 6 months of adjuvant chemotherapy. Prior therapy should have included an anthracycline unless clinically contraindicated.
- Locally advanced or metastatic non-small cell lung cancer (NSCLC), as first-line treatment in combination with carboplatin, in patients who are not candidates for curative surgery or radiation therapy.
- Metastatic adenocarcinoma of the pancreas as first-line treatment, in combination with gemcitabine.

Policy/Criteria
Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of PA Health & Wellness® that Abraxane 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. Disease is recurrent, metastatic, or unresponsive to preoperative systemic therapy;
3. Prescribed by or in consultation with an oncologist;
4. Age ≥ 18 years;
5. For Abraxane requests, member must use paclitaxel protein-bound particles, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Request meets one of the following (a or b):
   a. Dose does not exceed 260 mg/m^2 every 3 weeks;
   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. Non-Small Cell Lung Cancer (must meet all)**:**

1. Diagnosis of recurrent, advanced, or metastatic NSCLC;
2. Prescribed by or in consultation with an oncologist;

3. Age ≥ 18 years;
4. Member must use paclitaxel, unless contraindicated or clinically significant adverse effects are experienced;
5. For Abraxane requests, member must use paclitaxel protein-bound particles, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Request meets one of the following (a or b):
   a. Dose does not exceed 100 mg/m^2 IV on Days 1, 8, and 15 of each 21-day cycle;
   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. Adenocarcinoma of the Pancreas (must meet all)**:**
1. Diagnosis of adenocarcinoma of the pancreas;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Abraxane will be used in combination with gemcitabine*;
   **Gemcitabine may require prior authorization*
5. Disease is metastatic, unresectable, or borderline resectable;
6. For Abraxane requests, member must use paclitaxel protein-bound particles, if available, unless contraindicated or clinically significant adverse effects are experienced;
7. Request meets one of the following (a or b):
   a. Dose does not exceed 125 mg/m^2 on Days 1, 8 and 15 of each 28-day cycle;
   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. Additional NCCN Recommended Uses (off-label) (must meet all)**:**
1. Diagnosis of one of the indications supported by NCCN categories 1 and 2A (a - i):
   a. AIDS-related Kaposi sarcoma;
   b. Ampullary adenocarcinoma;
   c. Cutaneous or uveal melanoma, prescribed as a single agent;
   d. Cervical cancer;
   e. Endometrial carcinoma, prescribed as a single agent;
   f. Cholangiocarcinoma or gallbladder cancer, and member meets both of the following (i and ii):
      i. Disease is unresectable or metastatic;
      ii. Abraxane is prescribed in combination with gemcitabine;
   g. Relapsed ovarian cancer;
   h. Advanced or metastatic small bowel adenocarcinoma;
   i. Other NCCN category 1, 2A, or 2B recommendations;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;

4. For Abraxane requests, member must use paclitaxel protein-bound particles, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

E. Other diagnoses/indications *(including NCCN category I and 2A indications not already listed).*

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 previously met initial approval criteria; or the Continuity of Care policy (PA.LTSS.PHAR.01) applies;
2. Member is responding positively to therapy;
3. For Abraxane requests, member must use paclitaxel protein-bound particles, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, meets one of the following (a or b):
   a. New dose does not exceed one of the following (i, ii, or iii):
      i. For breast cancer: 260 mg/m^2 IV every 3 weeks;
      ii. For NSCLC: 100 mg/m^2 IV on Days 1, 8, and 15 of each 21-day cycle;
      iii. For adenocarcinoma of the pancreas: 125 mg/m^2 on Days 1, 8 and 15 of each 28-day cycle
   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 and documentation supports positive response to therapy; 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 PA.CP.PMN.53

III. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

EGFR: epidermal growth factor receptor
FDA: Food and Drug Administration
NSCLC: non-small cell lung cancer
HER2: human epidermal growth factor receptor 2

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
anthracyclines (e.g., doxorubicin, pegylated liposomal doxorubicin, epirubicin)	For breast cancer: Refer to prescribing information	Refer to prescribing information
paclitaxel (Taxol®)	For NSCLC: Various combinations	250 mg/m^2 every 3 weeks
gemcitabine (Gemzar®)	For adenocarcinoma of the pancreas: 1,000 mg/m^2 IV over 30 to 40 minutes on days 1, 8, and 15 preceded by nab-paclitaxel (125 mg/m^2 IV over 30 to 40 minutes on days 1, 8, and 15) every 28 days	1000 mg/m^2 once weekly for up to 7 consecutive weeks

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

- Contraindication(s): neutrophil counts of < 1,500 cells/mm^3, severe hypersensitivity
- Boxed warning(s): neutropenia

IV. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Metastatic breast cancer	260 mg/m^2 IV every 3 weeks	260 mg/m^2
Non-small cell lung cancer	100 mg/m^2 IV on days 1, 8, and 15 of each 21-day cycle	260 mg/m^2
Metastatic adenocarcinoma of the pancreas	125 mg/m^2 IV on days 1, 8 and 15 of each 28-day cycle	260 mg/m^2

V. Product Availability

Injectable suspension: lyophilized powder containing 100 mg of paclitaxel formulated as albumin-bound particles in single-use vial for reconstitution.

VI. References

1. Abraxane Prescribing Information. Summit, NJ: Celgene Corporation; August 2020. Available at http://www.abraxane.com/. Accessed January 6, 2023.
2. Paclitaxel, albumin bound. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed February 16, 2023.

3. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; Updated periodically. Accessed February 6, 2023.
4. National Comprehensive Cancer Network. Breast Cancer Version 2.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed February 7, 2023.
5. National Comprehensive Cancer Network. Pancreatic Adenocarcinoma Version 2.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/pancreatic.pdf Accessed January 10, 2023.
6. National Comprehensive Cancer Network. Non-Small Cell Lung Cancer Version 1.2032. Available at: https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed February 7, 2023.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included 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.

The following is a list of procedures codes for which coverage may be provided when billed with a diagnosis code(s) that supports coverage criteria (see list of ICD codes supporting coverage criteria further below).

CPT® /HCPCS Codes	Description
J9264	Injection, paclitaxel protein-bound particles, 1 mg

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

The following is a list of diagnosis codes that support coverage for the applicable covered procedure code(s).

ICD-10-CM Code	Description
C17.0	Malignant neoplasm of duodenum
C17.1	Malignant neoplasm of jejunum
C17.2	Malignant neoplasm of ileum
C17.3	Meckel's diverticulum, malignant
C17.8	Malignant neoplasm of overlapping sites of small intestine
C17.9	Malignant neoplasm of small intestine, unspecified
C22.1	Intrahepatic bile duct carcinoma
C23	Malignant neoplasm of gallbladder
C24.0-C24.9	Malignant neoplasm of other and unspecified parts of biliary tract
C25.0-C25.9	Malignant neoplasm of pancreas
C34.00-C34.02	Malignant neoplasm of main bronchus
C34.10-C34.12	Malignant neoplasm of upper lobe, bronchus or lung
C34.2	Malignant neoplasm of middle lobe, bronchus or lung
C34.30-C34.32	Malignant neoplasm of lower lobe, bronchus or lung

ICD-10-CM Code	Description
C34.80-C34.82	Malignant neoplasm of overlapping sites of bronchus or lung
C34.90-C34.92	Malignant neoplasm of unspecified part of unspecified bronchus or lung
C43.0-C43.8	Melanoma and other malignant neoplasms of skin
C46.0-C46.9	Kaposi's sarcoma
C48.1	Malignant neoplasm of specified parts of peritoneum
C48.2	Malignant neoplasm of peritoneum, unspecified
C48.8	Malignant neoplasm of overlapping sites of retroperitoneum and peritoneum
C50.011-C50.012	Malignant neoplasm of nipple and areola, female breast
C50.021-C50.022	Malignant neoplasm of nipple and areola, male breast
C50.111-C50.112	Malignant neoplasm of central portion of female breast
C50.121-C50.122	Malignant neoplasm of central portion of male breast
C50.211-C50.212	Malignant neoplasm of upper-inner quadrant of female breast
C50.221-C50.222	Malignant neoplasm of upper-inner quadrant of male breast
C50.311-C50.312	Malignant neoplasm of lower-inner quadrant of female breast
C50.321-C50.322	Malignant neoplasm of lower-inner quadrant of male breast
C50.411-C50.412	Malignant neoplasm of upper-outer quadrant of female breast
C50.421-C50.422	Malignant neoplasm of upper-outer quadrant of male breast
C50.511-C50.512	Malignant neoplasm of lower-outer quadrant of female breast
C50.521-C50.522	Malignant neoplasm of lower-outer quadrant of male breast
C50.611-C50.612	Malignant neoplasm of axillary tail of female breast
C50.621-C50.622	Malignant neoplasm of axillary tail of male breast
C50.811-C50.812	Malignant neoplasm of overlapping sites of female breast
C50.821-C50.822	Malignant neoplasm of overlapping sites of male breast
C50.9	Malignant neoplasm of breast of unspecified site
C54.1	Malignant neoplasm of endometrium
C56.1-C56.3	Malignant neoplasm of ovary
C57.01-C57.02	Malignant neoplasm of fallopian tube
C57.11-C57.12	Malignant neoplasm of broad ligament
C57.21-C57.22	Malignant neoplasm of round ligament
C57.3	Malignant neoplasm of parametrium
C57.4	Malignant neoplasm of uterine adnexa, unspecified
C57.7	Malignant neoplasm of other specified female genital organs
C57.8	Malignant neoplasm of overlapping sites of female genital organs

Reviews, Revisions, and Approvals	Date	Approval Date
2Q 2018 annual review: added age; NCCN category 2B indication for cervical cancer removed; for all indications: removed requirements to check for contraindications per safety guidance, summarized NCCN and FDA approved uses for improved clarity; added specialist involvement in care; references reviewed and updated.	02/2018	

Reviews, Revisions, and Approvals	Date	Approval Date
2Q 2019 annual review: added NCCN 2A off-label uses: endometrial carcinoma and hepatic cholangiocarcinoma; references reviewed and updated.	04/2019	
2Q 2020 annual review: added NCCN compendium-supported indications of small bowel adenocarcinoma and triple-negative breast cancer; references reviewed and updated.	04/2020	
Added ICD-10-CM codes C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, and C50.9	06/2020	
2Q 2021 annual review: clarified NSCLC to be recurrent, advanced or metastatic per NCCN and revised requirement of medical justification for inability to use paclitaxel to "must use" language; clarified hepatic cholangiocarcinoma as "cholangiocarcinoma," unresectable or metastatic and Abraxane prescribed in combination with gemcitabine per NCCN; references reviewed and updated.	04/2021	
2Q 2022 annual review: removed criterion for Abraxane+Tecentriq combination therapy in triple-negative breast cancer as this indication was withdrawn in August 2021 and no longer supported by NCCN; per NCCN, added "unresponsive to preoperative systemic therapy" as a breast cancer status, added gallbladder cancer indication, added single-agent therapy criterion for cutaneous melanoma, uveal melanoma, and endometrial carcinoma indications, removed bladder cancer indication as this is no longer supported; references reviewed and updated.	04/2022	
2Q 2023 annual review: removed criterion for prior anthracycline therapy for non-triple negative breast cancer per NCCN; added ampullary adenocarcinoma and cervical cancer as additional NCCN supported indications (off-label); removed HCPCS/CPT code 96413 and 96415; references reviewed and updated.	04/2023	