Prior Authorization Review Panel

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: 05/01/2022**
Policy Number: PA.CP.PHAR.475	**Effective Date: 07/15//2020** **Revision Date: 04/2022**
Policy Name: Sacituzumab Govitecan-hziy (Trodelvy)	

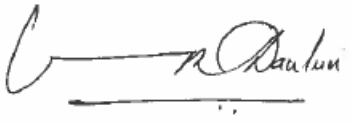
Type of Submission – Check all that apply:

- ☐ **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:

2Q 2022 annual review: for TNBC: removed "locally advanced" requirement as disease can be local or regional per NCCN; added recurrent urothelial carcinoma indication per NCCN; added criterion for use as single-agent therapy for both TNBC and urothelial cancer per NCCN; references reviewed and updated.

Name of Authorized Individual (Please type or print): **Venkateswara R. Davuluri, MD**	**Signature of Authorized Individual:** 

Clinical Policy: Sacituzumab Govitecan-hziy (Trodelvy)

Reference Number: PA.CP.PHAR.475
Effective Date: 07/2020
Last Review Date: 04/2022

Coding Implications
Revision Log

Description
Sacituzumab govitecan-hziy (Trodelvy™) is a Trop-2-directed antibody and topoisomerase inhibitor conjugate.

FDA Approved Indication(s)
Trodelvy is indicated for the treatment of adult patients with

- Unresectable locally advanced or metastatic triple-negative breast cancer (mTNBC) who have received two or more prior systemic therapies, at least one of them for metastatic disease
- Locally advanced or metastatic urothelial cancer who have previously received a platinum-containing chemotherapy and either programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PDL1) inhibitor*

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

I. Initial Approval Criteria

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

1. Diagnosis of unresectable or metastatic breast cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Documentation of triple negative (i.e., estrogen receptor-, progesterone receptor-, and human epidermal growth factor receptor 2 [HER2]-negative) disease;
5. Failure of both of the following (a and b):
   a. Two or more prior regimens (*see Appendix B*);
   b. At least one of the prior regimens administered for metastatic disease (*see Appendix B*);
6. Prescribed as a single agent;
7. Request meets one of the following (a or b):
   a. Dose does not exceed 10 mg/kg on days 1 and 8 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

B. Urothelial Cancer (must meet all)**:**
1. Diagnosis of locally advanced, recurrent or metastatic urothelial cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Failure of both of the following (a and b):
   a. Platinum-containing chemotherapy (*see Appendix B*);
   b. Programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor (*see Appendix B*);
5. Prescribed as a single agent;
6. Request meets one of the following (a or b):
   a. Dose does not exceed 10 mg/kg on days 1 and 8 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. Other diagnoses/indications
1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): 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 and documentation supports positive response to therapy 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 10 mg/kg on days 1 and 8 of each 21-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 the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53

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 policies – PA.CP.PMN.53

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
HER2: human epidermal growth factor receptor 2
PD-1: programmed death receptor-1
PD-L1: programmed death-ligand
TNBC: triple-negative breast 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 for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Examples of systemic therapies for recurrent unresectable or metastatic breast cancer		
paclitaxel	Varies	Varies
Abraxane® (albumin-bound paclitaxel)	Varies	Varies
docetaxel (Taxotere®)	Varies	Varies
doxorubicin	Varies	Varies
Liposomal doxorubicin (Doxil®)	50 mg/m^2 IV day 1, cycled every 28 days	Varies
capecitabine (Xeloda®)	1,000-1,250 mg/m^2 PO BID on days 1-14, cycled every 21 days	Varies
gemcitabine (Gemzar®)	800-1,200 mg/m^2 IV on days 1,8 and 15, cycled every 28 days	Varies
vinorelbine	Varies	Varies
Halaven® (eribulin)	1.4 mg/m^2 IV on days 1 and 8, cycled every 21 days	Varies
carboplatin	AUC 6 IV on day 1, cycled every 21-28 days	Varies
cisplatin	75 mg/m^2 IV on day 1, cycled every 21 days	Varies
cyclophosphamide	50 mg PO QD on days 1-21, cycled every 28 days	Varies
epirubicin (Ellence®)	60-90 mg/m^2 IV on day 1, cycled every 21 days	Varies
Ixempra® (ixabepilone)	40 mg/m^2 IV on day 1, cycled every 21 days	40 mg/m^2
Examples of platinum-containing regimens for urothelial cancer		
DDMVAC (dose-dense methotrexate, vinblastine, doxorubicin, and cisplatin)	Varies	Varies
gemcitabine with either cisplatin or carboplatin	Varies	Varies
Examples of PD-1 and PD-L1 inhibitors for urothelial cancer		
Keytruda® (pembrolizumab)	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Tecentriq® (atezolizumab)	Varies	Varies
Opdivo® (nivolumab)	Varies	Varies
Bavencio® (avelumab)	800 mg IV infusion once every 2 weeks	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

- Contraindication(s): severe hypersensitivity to Trodelvy
- Boxed warning(s): neutropenia and diarrhea

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Triple- negative breast cancer, urothelial cancer	10 mg/kg on days 1 and 8 of each 21-day cycle	10 mg/kg

VI. Product Availability

Vial: 180 mg lyophilized powder for reconstitution

VII. References

1. Trodelvy Prescribing Information. Morris Plains, NJ: Immunomedics, Inc.; October 2021. Available at: https://www.gilead.com/-/media/files/pdfs/medicines/oncology/trodelvy/trodelvy_pi.pdf. Accessed February 13, 2022.
2. Bardia A, Mayer IA, Vahdat LT, et al. Sacituzumab Govitecan-hziy in refractory metastatic triple-negative breast cancer. N Engl J Med 2019 Feb 21;380(8):741-51.
3. Sacituzumab govitecan. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed February 13, 2022.

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
J9317	Injection, sacituzumab govitecan-hziy, 2.5 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New Policy Created	07/2020	
2Q 2021 annual review: added criteria for new mUC indication; updated breast cancer criteria to add unresectable locally advanced option and clarified that of the two or more prior regimens, at least	04/2021	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
one of them be for metastatic disease, based on updated FDA-labeling; updated JCode; references reviewed and updated.		
2Q 2022 annual review: for TNBC: removed "locally advanced" requirement as disease can be local or regional per NCCN; added recurrent urothelial carcinoma indication per NCCN; added criterion for use as single-agent therapy for both TNBC and urothelial cancer per NCCN; references reviewed and updated.	04/2022	