POLICY Document for GEMZAR (gemcitabine) INFUGEM (gemcitabine) gemcitabine

The overall objective of this policy is to support the appropriate and cost-effective use of the medication, specific to use of preferred medication options, and overall, clinically appropriate use. This document provides specific information to both sections of the overall policy.

Section 1: Clinical Criteria
- Policy information specific to the clinical appropriateness for the medication

Section 2: Oncology Clinical Policy
- Policy information specific to regimen review per NCCN Guidelines.

Section 1: Clinical Criteria

Medical Prior Authorization gemcitabine

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Gemzar	gemcitabine
Infugem	gemcitabine
gemcitabine (all other brands)	gemcitabine

Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-approved Indications

Ovarian Cancer

In combination with carboplatin for the treatment of patients with advanced ovarian cancer that has relapsed at least 6 months after completion of platinum-based therapy

Breast Cancer

In combination with paclitaxel for the first-line treatment of patients with metastatic breast cancer after failure of prior anthracycline-containing adjuvant chemotherapy, unless anthracyclines were clinically contraindicated

Non-Small Cell Lung Cancer

In combination with cisplatin for the first-line treatment of patients with inoperable, locally advanced (Stage IIIA or IIIB), or metastatic (Stage IV) non-small cell lung cancer (NSCLC)

Pancreatic Cancer

As first-line treatment for patients with locally advanced (nonresectable Stage II or Stage III) or metastatic (Stage IV) adenocarcinoma of the pancreas. Gemzar, Infugem or gemcitabine is indicated for patients previously treated with fluorouracil.

Compendial Uses

- Ampullary adenocarcinoma
- Bladder cancer, primary carcinoma of the urethra, upper genitourinary tract tumors, transitional cell carcinoma of the urinary tract, urothelial carcinoma of the prostate, non-urothelial and urothelial cancer with variant histology
- Bone cancer
    - Ewing sarcoma
    - Osteosarcoma
- Breast cancer
- Cervical cancer
- Head and neck cancers (including very advanced head and neck cancer, cancer of the nasopharynx, occult primary and salivary gland tumors)
- Biliary tract cancer
    - Extrahepatic cholangiocarcinoma
    - Intrahepatic cholangiocarcinoma
    - Gallbladder cancer
- Hodgkin lymphoma
    - Classic Hodgkin lymphoma
    - Nodular lymphocyte-predominant Hodgkin lymphoma
- Kidney cancer
- Pleural or peritoneal mesothelioma
- Non-small cell lung cancer (NSCLC)
- Occult primary tumors (cancer of unknown primary)

- Ovarian cancer, fallopian tube cancer, and primary peritoneal cancer: epithelial ovarian cancer, fallopian tube cancer, and primary peritoneal cancer
- Pancreatic adenocarcinoma
- Small cell lung cancer (SCLC)
- Soft tissue sarcoma
    - Angiosarcoma
    - Extremity/Body wall, head/neck
    - Retroperitoneal/intra-abdominal
    - Rhabdomyosarcoma
    - Solitary fibrous tumor
    - Dedifferentiated chordoma
    - Dermatofibrosarcoma protuberans (DFSP) with fibrosarcomatous transformation
- Testicular cancer
- Thymomas and thymic carcinomas
- Uterine neoplasms (including endometrial carcinoma, uterine sarcoma and uterine leiomyosarcoma)
- Kaposi sarcoma
- Primary cutaneous lymphomas
    - Mycosis fungoides/Sezary syndrome
    - Primary cutaneous CD30+ T-Cell lymphoproliferative disorders
- T-Cell lymphomas
    - Peripheral T-Cell lymphomas
    - Adult T-Cell leukemia/lymphoma
    - Breast implant-associated anaplastic large cell lymphoma
    - Extranodal natural killer (NK)/T-Cell lymphoma
    - Hepatosplenic T-Cell lymphoma
- Gestational trophoblastic neoplasia
- B-Cell lymphomas
    - Histologic transformation of indolent lymphomas to diffuse large B-Cell lymphoma
    - Mantle cell lymphoma
    - Diffuse large B-Cell lymphoma
    - High-Grade B-Cell lymphomas
    - Burkitt lymphoma
    - Human immunodeficiency virus (HIV)-Related B-Cell lymphomas
    - Post-Transplant lymphoproliferative disorders
- Small bowel adenocarcinoma
- Malignant germ cell tumor
- Vaginal cancer
- Vulvar cancer

All other indications are considered experimental/investigational and not medically necessary.

Coverage Criteria

Pancreatic Adenocarcinoma

Authorization of 6 months may be granted for treatment of pancreatic adenocarcinoma.

Breast Cancer

Authorization of 6 months may be granted for treatment of members with no response to preoperative systemic therapy, recurrent, or metastatic breast cancer.

Biliary Tract Cancer

Authorization of 6 months may be granted for treatment of biliary tract cancer (including intrahepatic and extrahepatic cholangiocarcinoma, and gallbladder cancer).

Ampullary Adenocarcinoma

Authorization of 6 months may be granted for treatment of ampullary adenocarcinoma.

Ovarian Cancer, Fallopian Tube Cancer, and Primary Peritoneal Cancer

Authorization of 6 months may be granted for treatment of advanced, persistent, or recurrent epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer, carcinosarcoma (malignant mixed Mullerian tumors), clear cell carcinoma of the ovary, grade 1 endometrioid carcinoma, low-grade serous carcinoma/ovarian borderline epithelial tumors (low malignant potential), mucinous carcinoma of the ovary, or malignant germ cell tumor residual disease.

Non-Small Cell Lung Cancer (NSCLC)

Authorization of 6 months may be granted for treatment of NSCLC.

Cervical Cancer

Authorization of 6 months may be granted for treatment of cervical cancer.

-Bladder Cancer, Primary Carcinoma of the Urethra, Upper Genitourinary Tract Tumors, Transitional Cell Carcinoma of the Urinary Tract, Urothelial Carcinoma of the Prostate, and Non-Urothelial and Urothelial Cancer with Variant Histology

Authorization of 6 months may be granted for treatment of bladder cancer, primary carcinoma of the urethra, upper genitourinary tract tumors, transitional cell carcinoma of the urinary tract, urothelial carcinoma of the prostate, and non-urothelial and urothelial cancer with variant histology.

Small Cell Lung Cancer (SCLC)

Authorization of 6 months may be granted for treatment of SCLC.

Soft Tissue Sarcoma

Authorization of 6 months may be granted for treatment of soft tissue sarcoma (including angiosarcoma, extremity/body wall, head/neck, retroperitoneal/intra-abdominal, rhabdomyosarcoma, solitary fibrous tumor, dedifferentiated chordoma, and dermatofibrosarcoma protuberans (DFSP) with fibrosarcomatous transformation).

Bone Cancer

Ewing Sarcoma

Authorization of 6 months may be granted for treatment of relapsed, progressive, or metastatic Ewing sarcoma.

Osteosarcoma

Authorization of 6 months may be granted for treatment of relapsed/refractory or metastatic osteosarcoma.

Head and Neck Cancer

Authorization of 6 months may be granted for treatment of head and neck cancer (including very advanced head and neck cancer, cancer of the nasopharynx, occult primary, and salivary gland tumors).

Hodgkin Lymphoma

Hodgkin Lymphoma

Authorization of 6 months may be granted for treatment of Hodgkin lymphoma including classic Hodgkin lymphoma and pediatric Hodgkin lymphoma.

Nodular Lymphocyte-Predominant Hodgkin Lymphoma

Authorization of 6 months may be granted for treatment of progressive, relapsed, or refractory nodular lymphocyte-predominant Hodgkin lymphoma.

Kidney Cancer

Authorization of 6 months may be granted for treatment of relapsed or metastatic kidney cancer.

Pleural or Peritoneal Mesothelioma

Authorization of 6 months may be granted for treatment of pleural or peritoneal mesothelioma, including pericardial mesothelioma and tunica vaginalis testis mesothelioma.

Occult Primary Tumors (cancer of unknown primary)

Authorization of 6 months may be granted for treatment of occult primary tumors.

Testicular Cancer

Authorization of 6 months may be granted for treatment of testicular cancer.

Thymomas and Thymic Carcinomas

Authorization of 6 months may be granted for treatment of thymomas and thymic carcinomas.

Uterine Neoplasms

Authorization of 6 months may be granted for treatment of uterine neoplasms (including endometrial carcinoma, uterine sarcoma and uterine leiomyosarcoma).

Kaposi Sarcoma

Authorization of 6 months may be granted for treatment of Kaposi sarcoma.

Primary Cutaneous Lymphomas

Authorization of 6 months may be granted for treatment of primary cutaneous lymphomas (including mycosis fungoides/Sezary syndrome and primary cutaneous CD30+ T-Cell lymphoproliferative disorders).

T-Cell Lymphomas

Authorization of 6 months may be granted for treatment of T-Cell lymphomas (including peripheral T-Cell lymphomas, adult T-Cell leukemia/lymphoma, hepatosplenic T-Cell lymphoma, breast implant-associated anaplastic large cell lymphoma, and extranodal NK/T-Cell lymphoma).

Gestational Trophoblastic Neoplasia

Authorization of 6 months may be granted for treatment of gestational trophoblastic neoplasia.

B-Cell Lymphomas

Authorization of 6 months may be granted for treatment of B-Cell lymphomas (including histologic transformation of indolent lymphomas to diffuse large B-Cell lymphoma, mantle cell lymphoma, diffuse large B-Cell lymphoma, high-grade B-Cell lymphomas, Burkitt lymphoma, HIV-Related B-Cell lymphomas, and post-transplant lymphoproliferative disorders).

Small Bowel Adenocarcinoma

Authorization of 6 months may be granted for treatment of small bowel adenocarcinoma.

Malignant Germ Cell Tumor

Authorization of 6 months may be granted for treatment of malignant germ cell tumor.

Vaginal Cancer

Authorization of 6 months may be granted for treatment of vaginal cancer when used as a single agent.

Vulvar Cancer

Authorization of 6 months may be granted for treatment of vulvar cancer as concurrent chemoradiation as a single agent if cisplatin or carboplatin are unavailable.

Continuation of Therapy

Authorization of 6 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

Section 2: Oncology Clinical Policy

PURPOSE

The purpose of this policy is to define the Novologix NCCN® Regimen Prior Authorization Program.

SCOPE

This policy applies to clients who have implemented the Novologix NCCN® Program as a part of their medical and/or pharmacy prior authorization solution.

PROGRAM DESCRIPTION

The National Comprehensive Care Network® (NCCN®) is an alliance of leading cancer centers devoted to patient care, research and education dedicated to improving the quality, effectiveness, and efficiency of cancer care so patients can live better lives.[1] It is comprised of oncology experts who convene regularly to establish the best treatments for patients. NCCN develops various resources for use by stakeholders in the health care delivery system. These resources include, but are not limited to, the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®), the NCCN Drugs & Biologics Compendium (NCCN Compendium®) and the NCCN Chemotherapy Order Templates (NCCN Templates®).

NCCN Templates® are based on NCCN Guidelines® and NCCN Compendium®. The NCCN Compendium lists the appropriate drugs and biologics as treatment options for specific cancers using U.S. Food and Drug

Administration (FDA)-approved disease indications and specific NCCN panel recommendations. Each recommendation is supported by a level of evidence category.

NCCN Categories of Evidence and Consensus[2]

- Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
- Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
- Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
- Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

POLICY

Policy for Regimen Prior Authorization

A regimen prior authorization allows submission of a single prior authorization request for all oncology drugs or biologics within an NCCN template that require prior authorization.

PROCEDURE

This policy provides coverage of a regimen review when all of the following criteria are met:

1. Regimen prior authorization reviews, based on NCCN templates, are initiated through the provider portal.
   - If the prior authorization request is submitted via phone or fax, each drug or biologic will need to be submitted and reviewed as a separate prior authorization request for review with drug-specific criteria.
2. The prior authorization review is requested for an oncology drug or biologic.
3. The member is eligible for regimen review.
4. The indication is for a cancer that is eligible for regimen review. Currently, the cancer types in scope for regimen review include the following:
   - Ampullary Adenocarcinoma
   - Anal Carcinoma
   - B-Cell Lymphomas
   - Basal Cell Skin Cancer
   - Biliary Tract Cancers
   - Bone Cancer
   - Breast Cancer
   - Bladder Cancer
   - Central Nervous System Cancers
   - Cervical Cancer
   - Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
   - Chronic Myeloid leukemia
   - Colon Cancer
   - Dermatofibrosarcoma Protuberans

- Esophageal Cancer
- Gastric Cancer
- Gastrointestinal Stromal Tumors
- Gestational Trophoblastic Neoplasms
- Hairy Cell Leukemia
- Head and Neck Cancers
- Histiocytic Neoplasms
- Hodgkin Lymphoma
- Hepatocellular Carcinoma
- Kaposi Sarcoma
- Kidney Cancer
- Melanoma: Cutaneous
- Melanoma: Uveal
- Merkel Cell Carcinoma
- Mesothelioma: Peritoneal
- Mesothelioma: Pleural
- Multiple Myeloma
- Myelodysplastic Syndromes
- Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions
- Myeloproliferative Neoplasms
- Neuroendocrine and Adrenal Tumors
- Non-Small Cell Lung Cancer
- Occult Primary
- Ovarian Cancer
- Pancreatic Cancer
- Penile Cancer
- Primary Cutaneous Lymphomas
- Prostate Cancer
- Rectal Cancer
- Small Bowl Adenocarcinoma
- Small Cell Lung Cancer
- Soft Tissue Sarcoma
- Squamous Cell Skin Cancer
- Systemic Mastocytosis
- Systemic Light Chain Amyloidosis
- T-Cell Lymphomas
- Testicular Cancer
- Thymomas and Thymic Carcinomas
- Thyroid Carcinoma
- Uterine Neoplasms
- Vaginal Cancer
- Vulvar Cancer
- Waldenström Macroglobulinemia / Lymphoplasmacytic Lymphoma
- Wilms Tumor (Nephroblastoma)

In addition, the following criteria must be met for approval:

1. The requested regimen for the drug(s) or biologic(s) and indication is consistent with an NCCN recommendation with a level of evidence category of 1 or 2A.
2. The NCCN template must be accepted by the provider without modification.

Further review may be indicated when the above criteria are not met.

Authorizations may be granted for 12 months or as medically required, based on the member's condition and provider's assessment.

Supportive Care: Myeloid Growth Factor Therapy
Granulocyte colony stimulating factors are recommended for primary prophylaxis based on the febrile neutropenia risk of the chemotherapy regimen. Febrile neutropenia risk levels vary by NCCN Chemotherapy Order template and are listed at the top of the template. Regimens associated with a high or intermediate risk of febrile neutropenia may include a granulocyte colony stimulating factor as part of the prior authorization.

Continuation of Therapy
To submit a request for continuation of therapy, a new regimen prior authorization review must be requested. Upon template selection, the template must be modified to include the appropriate therapies being used for maintenance treatment. The regimen request will be submitted for further review.

Dosage and Administration
Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and evidence-based practice guidelines.

REFERENCES:

SECTION 1

1. Gemzar [package insert]. Indianapolis, IN: Lilly USA, LLC; May 2019.
2. Infugem [package insert]. Cranbury, NJ: Sun Pharmaceutical Industries, Inc.; January 2020.
3. Gemcitabine [package insert]. Chicago, IL: Meitheal Pharmaceuticals; August 2019.
4. The NCCN Drugs & Biologics Compendium® © 2023 National Comprehensive Cancer Network, Inc. Available at: https://www.nccn.org. Accessed October 9, 2023.
5. Lexicomp [database online]. Hudson, OH: Lexi-Comp, Inc.; https://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed July 14, 2023.
6. Clinical Pharmacology [database online]. Tampa, FL: Elsevier; https://www.clinicalkey.com/pharmacology [available with subscription]. Accessed July 14, 2023.
7. Micromedex Solutions [database online]. Ann Arbor, MI: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed July 14, 2023.

SECTION 2

1. National Comprehensive Cancer Network. About NCCN website. https://www.nccn.org/home/about, accessed September 9, 2024.
2. National Comprehensive Cancer Network. NCCN Categories of Evidence and Consensus website, https://www.nccn.org/guidelines/guidelines-process/development-and-update-of-guidelines, accessed September 9, 2024.
3. National Comprehensive Cancer Network. NCCN Guidelines website. https://www.nccn.org/guidelines/category_1, accessed September 9, 2024. (Note: An account may be required.)

4. National Comprehensive Cancer Network. NCCN Drugs and Biologics Compendium website https://www.nccn.org/compendia-templates/compendia/drugs-and-biologics-compendia, accessed September 9, 2024. (Note: A subscription may be required.)
5. 5. National Comprehensive Cancer Network. NCCN Chemotherapy Order Templates (NCCN Templates) website. https://www.nccn.org/compendia-templates/nccn-templates-main/browse-by-cancer-type, accessed September 9, 2024. (Note: A subscription may be required.)