PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Afinitor Prior Authorization Policy
- Afinitor® (everolimus tablets – Novartis, generics 2.5 mg, 5 mg, 7.5 mg)
- Afinitor Disperz® (everolimus tablets for oral suspension – Novartis)

REVIEW DATE: 01/27/2021

OVERVIEW

Afinitor, a kinase inhibitor, is indicated for the following conditions:[1]

- **Breast cancer**, treatment of postmenopausal women with advanced hormone receptor-positive (HR+), human epidermal growth factor receptor 2 (HER2)-negative disease (advanced HR+ breast cancer) in combination with exemestane, after failure of treatment with letrozole or anastrozole.
- **Neuroendocrine tumors (NET)**, treatment of adult patients with progressive disease of pancreatic origin (PNET) and adults with progressive, well-differentiated, non-functional NET of gastrointestinal or lung origin that are unresectable, locally advanced or metastatic. Limitation of Use: Afinitor is not indicated for the treatment of patients with functional carcinoid tumors.
- **Renal cell carcinoma**, treatment of adult patients with advanced disease after failure of treatment with Sutent® (sunitinib capsules) or Nexavar® (sorafenib tablets).
- **Tuberous sclerosis complex (TSC)-associated renal angiomyolipoma,** treatment of adult patients with this disease not requiring immediate surgery.
- **TSC-associated subependymal giant cell astrocytoma (SEGA)**, treatment of adult and pediatric patients ≥ 1 year of age with TSC for the treatment of SEGA that requires therapeutic intervention but cannot be curatively resected. Afinitor Disperz is also FDA-approved for this indication.
- **TSC-associated partial-onset seizures**, adjunctive treatment of adult and pediatric patients ≥ 2 years of age. Afinitor Disperz is FDA-approved for this indication.

Of note, Zortress®, (everolimus tablets) is indicated in combination with other drugs for prophylaxis of organ rejection in adult patients undergoing kidney or liver transplant.[2] The tablet strengths and dosing is different for Zortress than with Afinitor.

Guidelines

The National Comprehensive Cancer Network (NCCN) Compendium recommends use of everolimus for the indications listed in the FDA-approved and Other Uses with Supportive Evidence sections.[3] All of the recommendations are category 1 or category 2A.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Afinitor and Afinitor Disperz. All approvals are provided for the duration noted below. In the clinical criteria, as appropriate, an asterisk (*) is noted next to the specified gender. In this context, the specified gender is defined as follows: a woman is defined as an individual with the biological traits of a woman, regardless of the individual's gender identity or gender expression; men are defined as individuals with the biological traits of a man, regardless of the individual's gender identity or gender expression.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Afinitor (generics) and Afinitor Disperz is recommended in those who meet the following criteria:

FDA-Approved Indications

1. **Breast Cancer.** Approve for 3 years if the patient meets the following criteria (A, B, C, D, E, and F):
   - **A)** Patient has recurrent or Stage IV, hormone receptor positive (HR+) [i.e., estrogen receptor positive {ER+} and/or progesterone receptor positive {PR+}] disease; AND
   - **B)** Patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer; AND
   - **C)** Patient has tried at least one prior endocrine therapy (e.g., anastrozole, letrozole, or tamoxifen); AND
   - **D)** Patient meets ONE of the following conditions (i or ii):
     - **i.** Patient is a postmenopausal female* or a male*; OR
     - **ii.** Patient is premenopausal or perimenopausal AND is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist or has had surgical bilateral oophorectomy or ovarian irradiation; AND
       Note: Examples are Lupron® (leuprolide), Trelstar® (triptorelin), Zoladex® (goserelin).
   - **E)** Patient meets ONE of the following conditions (i or ii):
     - **i.** If patient is a male AND if Afinitor will be used in combination with exemestane, the patient is receiving a gonadotropin-releasing hormone (GnRH) agonist; OR
       Note: Examples are Lupron [leuprolide], Trelstar [triptorelin], Zoladex (goserelin).
     - **ii.** Afinitor will be used in combination with exemestane, fulvestrant, or tamoxifen; AND
   - **F)** Patient has not had disease progression while on Afinitor.

   ***** Refer to the Policy Statement.

2. **Neuroendocrine Tumors of the Pancreas, Gastrointestinal Tract, Lung and Thymus (Carcinoid Tumors) – Advanced, Unresectable, or Metastatic.** Approve for 3 years.

3. **Renal Cell Carcinoma (Clear Cell or Non-Clear Cell Histology).** Approve for 3 years if the patient meets the following criteria (A and B):
   - **A)** Patient has relapsed or Stage IV disease; AND
   - **B)** If using for clear cell disease, the patient has tried at least one prior systemic therapy.
     Note: Examples of prior systemic therapy are Inlyta [axitinib tablets], Votrient (pazopanib tablets), Sutent (sunitinib capsules), Cabometyx (cabozantinib tablets), Nexavar [sorafenib tablets].

4. **Tuberous Sclerosis Complex (TSC)-Associated Renal Angiomyolipoma.** Approve for 3 years.

5. **Tuberous Sclerosis Complex (TSC)-Associated Subependymal Giant Cell Astrocytoma (SEGA).** Approve for 3 years if therapeutic intervention is required but SEGA cannot be curatively resected.

6. **Tuberous Sclerosis Complex (TSC)-Associated Partial Onset Seizures.** Approve for 3 years.

Other Uses with Supportive Evidence

7. **Differentiated (i.e., papillary, follicular, and Hürthle cell) Thyroid Carcinoma.** Approve for 3 years if refractory to radioactive iodine therapy.

8. **Endometrial Carcinoma.** Approve for 3 years if the patient meets the following criteria (A and B):
   - **A)** The medication will be used in combination with letrozole; AND
   - **B)** Patient has recurrent, metastatic, or high-risk disease.

9. **Gastrointestinal Stromal Tumors (GIST).** Approve for 3 years if the patient meets the following criteria (A, B, C, and D):
   A) Patient has tried imatinib (Gleevec® tablets, generics); AND
   B) Patient has tried Sutent® (sunitinib capsules); AND
   C) Patient has tried Stivarga® (regorafenib tablets); AND
   D) The medication will be used in combination with imatinib (Gleevec tablets, generics), Sutent, or Stivarga.

10. **Classic Hodgkin Lymphoma.** Approve for 3 years in adults ≥ 18 years of age with relapsed or refractory disease.

11. **Meningioma.** Approve for 3 years if the patient has recurrent or progressive disease.

12. **Soft Tissue Sarcoma – Perivascular Epitheloid Cell Tumors (PEComa), Recurrent Angiomyolipoma, Lymphangioleiomyomatosis.** Approve for 3 years.

13. **Thymomas and Thymic Carcinomas.** Approve for 3 years if the patient has tried chemotherapy. Note: Examples are cisplatin plus doxorubicin, cisplatin plus etoposide, carboplatin plus paclitaxel.

14. **Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma (WM/LPL).** Approve for 3 years in patients who meet the following criteria (A or B):
   A) Patient has not responded to primary therapy; OR
   Note: Examples are Velcade® [bortezomib intravenous or subcutaneous injection] with dexamethasone; Treanda® [bendamustine intravenous], Rituxan combination therapies; Velcade; Velcade with dexamethasone; Kyprolis® [carfilzomib intravenous injection] with Rituxan and dexamethasone; cyclophosphamide/doxorubicin/vincristine/prednisone/Rituxan; Imbruvica® [ibrutinib capsules]; Rituxan.
   B) Patient has progressive or relapsed disease.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Afinitor (generics) and Afinitor Disperz is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Afinitor® tablets, Afinitor Disperz® tablets for oral suspension [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; February 2020.
2. Zortress® tablets [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; January 2018.
3. The NCCN Drugs & Biologics Compendium. © 2021 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed on January 25, 2021. Search term: everolimus.