# PRIOR AUTHORIZATION POLICY

**POLICY:** Oncology – Vizimpro Prior Authorization Policy
- Vizimpro® (dacomitinib tablets – Pfizer Labs)

**REVIEW DATE:** 10/21/2020

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## OVERVIEW

Vizimpro, a kinase inhibitor, is indicated for the first-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutations as detected by an FDA-approved test.[1]

## Guidelines

The National Comprehensive Cancer Network (NCCN) guidelines for NSCLC (version 8.2020 – September 15, 2020) recommends Vizimpro, Tarceva® (erlotinib tablets), Iressa® (gefitinib tablets), Gilotrif™ (afatinib tablets) and Tagrisso™ (osimertinib tablets) [all category 1] for the first-line treatment of patients with sensitizing *EGFR*-mutation positive NSCLC discovered before first-line chemotherapy.[2] Tagrisso is noted as the "preferred" option; whereas the rest of the agents are "Other Recommended" first-line therapies. Upon disease progression, T790M testing is recommended. Tagrisso is a category 1 recommended option if T790M mutation-positive. Patients can also continue Vizimpro, Tarceva, Gilotrif, or Iressa (category 2A).

## POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Vizimpro. All approvals are provided for 3 years in duration as noted below.

**Automation:** None.

## RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Vizimpro is recommended in those who meet the following criteria:

### FDA-Approved Indications

1. **Non-Small Cell Lung Cancer (NSCLC) – Epidermal Growth Factor Receptor (EGFR) Mutation-Positive.** Approve for 3 years if the patient meets the following criteria (A and B):
   - **A)** Patient has *metastatic* NSCLC; AND
   - **B)** Patient meets ONE of the following criteria (i or ii):
     - **i.** Patient has epidermal growth factor receptor (EGFR) exon 19 deletion as detected by an approved test; OR
     - **ii.** Patient has exon 21 (L858R) substitution mutations as detected by an approved test.

## CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Vizimpro 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. Vizimpro® tablets [prescribing information]. New York, NY: Pfizer Labs; September 2018.
2. The NCCN Non-Small Cell Lung Cancer Clinical Practice Guidelines in Oncology (Version 8.2020 – September 15, 2020) © 2020 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed October 21, 2020.