BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

PHARMACY COVERAGE GUIDELINES	**ORIGINAL EFFECTIVE DATE: 01/01/16**
SECTION: DRUGS	**LAST REVIEW DATE: 02/21/19**
	LAST CRITERIA REVISION DATE: 02/21/19
	ARCHIVE DATE:

IMBRUVICA® (ibrutinib) oral capsule and tablet

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

IMBRUVICA® (ibrutinib) oral capsule and tablet (cont.)

Criteria:

- **Criteria for initial therapy**: Imbruvica (ibrutinib) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Prescriber is an Oncologist

  2. Individual is 18 years of age or older

  3. A confirmed diagnosis of **ONE** of the following:
     - Follicular Lymphoma (grade 1-2), as a single agent for second-line or subsequent therapy (if not previously given as first-line) for refractory or progressive disease
     - Gastric or non-gastric mucosa-associated lymphoid tissue (MALT) lymphoma as second line or subsequent therapy for recurrent or progressive disease
     - Nodal or splenic marginal zone lymphoma (MZL) as second-line or subsequent therapy
     - Transformation of MZL to Diffuse Large B-cell Lymphoma treatment in patients who have received multiple lines of chemoimmunotherapy for indolent or transformed disease
     - Mantle cell lymphoma (MCL) as second-line or subsequent therapy as a single agent or in combination with lenalidomide and rituximab, or rituximab alone, for relapsed, refractory, or progressive disease; or in combination with rituximab as pre-treatment in order to limit the number of cycles of less aggressive induction therapy with RHyperCVAD
     - Diffuse Large B-cell Lymphoma as second-line or subsequent therapy for partial response, no response, relapsed, progressive or refractory non-germinal center diffuse large B-cell lymphoma in non-candidates for transplant
     - High-Grade B-cell Lymphoma as second-line or subsequent therapy for partial response, no response, relapsed, progressive, or refractory disease in non-candidates for transplant
     - AIDS-Related B-Cell Lymphomas, as second-line or subsequent therapy as a single agent for relapse of AIDS-related non-germinal center diffuse large B-cell lymphoma in non-candidates for transplant
     - Post-Transplant Lymphoproliferative Disorders, as second-line and subsequent therapy for patients with partial response, persistent or progressive disease after receiving chemoimmunotherapy as first-line treatment for monomorphic PTLD (non-germinal center B-cell type)
     - Primary CNS lymphoma as a single agent for relapsed or refractory disease
     - Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL) with or without del (17p)/TP53 mutation

IMBRUVICA® (ibrutinib) oral capsule and tablet (cont.)

- Hairy Cell Leukemia as a single agent for progression after therapy for relapsed/refractory disease
- Waldenström's macroglobulinemia /Lymphoplasmacytic Lymphoma as a single agent or in combination with rituximab
- Chronic graft versus host disease (cGVHD) after failure of one or more lines of system therapy
- Other request for a specific oncologic direct treatment use that is found and listed in the National Comprehensive Cancer Network (NCCN) Guidelines with Categories of Evidence and Consensus of 1 and 2A

4. **ALL** of the following baseline tests have been completed before initiation of treatment:
   - Comprehensive metabolic panel to assess liver function and risk for tumor lysis syndrome
   - Pregnancy test in a woman of child bearing age, unless is using effective contraception

Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Imbruvica (ibrutinib) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Individual continues to be seen by an Oncologist
2. Individual's condition has not worsened while on therapy
3. Individual has been adherent with the medication
4. Individual has not developed any significant level 4 adverse drug effects that may exclude continued use
   - Significant adverse effect such as:
     - Hemorrhage
     - Cytopenias
     - Cardiac arrhythmia
     - Tumor Lysis Syndrome (TLS)
5. There are no significant interacting drugs

Renewal duration: 6 months

IMBRUVICA® (ibrutinib) oral capsule and tablet (cont.)

Description:

Imbruvica (ibrutinib) is an inhibitor of Bruton's tyrosine kinase (BTK). Imbruvica (ibrutinib) is indicated for the treatment of patients with mantle cell lymphoma (MCL) who have received at least one prior therapy; for the treatment of chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL); for the treatment of chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) with 17p deletion; for the treatment of Waldenström's macroglobulinemia (WM); for the treatment of marginal zone lymphoma (MZL) for individuals that require systemic therapy when at least one prior anti-CD20-based therapy has been used; and for chronic graft versus host disease (cGVHD) after failure of one or more lines of system therapy.

Ibrutinib forms a covalent bond with a cysteine residue in the BTK active site, leading to inhibition of BTK enzymatic activity. BTK is a signaling molecule of the B-cell antigen receptor (BCR) and cytokine receptor pathways. BTK's role in signaling through the B-cell surface receptors results in activation of pathways necessary for B-cell trafficking, chemotaxis, and adhesion. Nonclinical studies show that ibrutinib inhibits malignant B-cell proliferation and survival *in vivo* as well as cell migration and substrate adhesion *in vitro*.

Resources:

NCCN Drugs & Biologics Compendium Imbruvica accessed 02-03-19

Off Label Use of Cancer Medications: A.R.S. §§ 20-826(R) & (S). Subscription contracts; definitions.

Off Label Use of Cancer Medications: A.R.S. §§ 20-1057(V) & (W). Evidence of coverage by health care service organizations; renewability; definitions.

Imbruvica. Package Insert. Revised by manufacturer 02/2018. Accessed 02-28-2018.

Imbruvica. Package Insert. Revised by manufacturer 01/2015. Accessed 08-04-2015.

Imbruvica. Package Insert. Revised by manufacturer 05/2016. Accessed 05-12-2016.

Imbruvica. Package Insert. Revised by manufacturer 06/2016. Accessed 07-22-2016.

Imbruvica. Package Insert. Revised by manufacturer 01/2017. Accessed 02-02-2017.

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information

Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

Prescribing Provider Information

Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information

Medication Name:	Strength:		Dosage Form:
Directions for Use:	Quantity:	Refills:	Duration of Therapy/Use:

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: _____ ☐ Exigent (requires prescriber to include a written statement)

Clinical Information

1. **What is the diagnosis? Please specify below.**

   ICD-10 Code: _____ **Diagnosis Description:** _____

2. ☐ Yes ☐ No **Was this medication started on a recent hospital discharge or emergency room visit?**

3. ☐ Yes ☐ No **There is absence of ALL contraindications.**

4. **What medication(s) has the individual tried and failed for this diagnosis? Please specify below.**
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. **Are there any supporting labs or test results? Please specify below.**

Date	Test	Value

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Pharmacy Prior Authorization Request Form

6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature: Date:

Please note: Some medications may require completion of a drug-specific request form.

Incomplete forms or forms without the chart notes will be returned.

Office notes, labs, and medical testing relevant to the request that show medical justification are required.