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

PHARMACY COVERAGE GUIDELINES	**ORIGINAL EFFECTIVE DATE: 1/21/16**
SECTION: DRUGS	**LAST REVIEW DATE: 1/18/18**
	LAST CRITERIA REVISION DATE: 1/18/18
	ARCHIVE DATE:

ALECENSA® (alectinib) oral capsule

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.**

ALECENSA® (alectinib) oral capsule (cont.)

Description:

Alecensa (alectinib) is a tyrosine kinase inhibitor that is indicated for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC).

Alectinib binds to and inhibits ALK kinase. Inhibition leads to disruption of ALK-mediated signaling and eventually inhibits tumor cell growth in ALK-overexpressing tumor cells. ALK belongs to the insulin receptor superfamily and plays an important role in nervous system development. ALK dysregulation and gene rearrangements are associated with a series of tumors.

Lung cancer:

- Lung cancer is the second most common cancer in the United States and it is the leading cause of cancer-related mortality

- There are two main types of lung cancer:
  - Small cell lung cancer (SCLC)
    - SCLC is also known as “oat-cell” cancer because the cells look like oats under the microscope
  - Non-small cell lung cancer (NSCLC)
    - NSCLC is the most common type of lung cancer and is seen in 85-90% of lung cancers
    - NSCLC can be either squamous or non-squamous type
    - Classification:
      - Adenocarcinoma
      - Adenosquamous carcinoma
      - Large-cell undifferentiated carcinoma
      - Sarcomatoid carcinoma which includes pleomorphic carcinoma, carcinosarcoma, and pulmonary blastoma
      - Squamous cell carcinoma
        - Squamous (epidermoid) cells are thin, flat cells that look like fish scales
        - Squamous cells are seen in the tissues that line the larger airways
      -
    - Non-squamous cancers usually begin in more distal airway

- Distribution of various NSCLC types:
  - About 40% of lung cancers are adenocarcinomas
  - About 25-30% of lung cancers are squamous cell carcinomas
  - About 10-15% of lung cancers are large cell undifferentiated carcinomas

- Brain metastases are a frequent complication of NSCLC, with 25-40% of patients developing brain metastases during the course of the disease
  - Many patients with brain metastases are not eligible for radiation therapy due to poor performance status

- An estimated 2-7% NSCLC are found to have ALK gene rearrangements and 15% of NSCLC cases have epidermal growth factor receptor (EGFR) mutations
  - ALK rearrangements and sensitizing EGFR mutations are generally mutually exclusive

ALECENSA® (alectinib) oral capsule (cont.)

- Central nervous system progression is common with ALK gene rearrangements and accounts for significant morbidity and mortality among these patients
- Individuals who are relatively young, never or light smokers with adenocarcinoma are most likely to have ALK gene rearrangements

- National Comprehensive Cancer Network (NCCN) version 2.2018 (12-19-2017)
  - ALK rearrangement positive:
    - First-line therapy: (category 1)
      - Alectinib – preferred
      - Certinib
      - Crizotinib
    - Progression:
      - On crizotinib, subsequent therapy:
        - Consider local therapy
        - Continue crizotinib or
        - Alectinib, if not previously used or
        - Certinib, if not previously used or
        - Brigatinib
      - On alectinib or certinib, subsequent therapy:
        - Consider local therapy
        - Continue alectinib or certinib

Alecensa (alectinib hydrochloride)

Medication class:
Antineoplastic Agent, Anaplastic Lymphoma Kinase Inhibitor, Tyrosine Kinase Inhibitor

FDA-approved indication(s):
- For the treatment of patients with anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC)

Recommended Dose:
- 600mg orally twice daily with food

Available Dosage Forms:
- 150mg capsule

Warnings and Precautions:
- Discontinue is patients are unable to tolerate a dose of 300 mg twice daily
- The safety of Alecensa in patients with moderate or severe hepatic impairment has not been studied
- Hepatotoxicity may occur, in case of severe ALT, AST, or bilirubin elevations, withhold, reduce dose, or permanently discontinue Alecensa
- Permanently discontinue for severe hepatic impairment (total bilirubin > 2x ULN with ALT or AST > 3x ULN in the absences of cholestasis or hemolysis

ALECENSA® (alectinib) oral capsule (cont.)

- Interstitial Lung Disease (ILD)/Pneumonitis may occur, hold Alecensa in patients diagnosed with ILD/pneumonitis and permanently discontinue if no other potential causes of ILD/pneumonitis have been identified
- The safety of Alecensa in patients with severe renal impairment (creatinine clearance < 30 mL/min) or end-stage renal disease has not been studied
- Permanently discontinue Alecensa for significant renal impairment
- Bradycardia (heart rate < 60 bpm that has life-threatening consequences, needing urgent intervention) may occur, if symptomatic, withhold, reduce dose, or permanently discontinue if no other identifiable cause is found
- Permanently discontinue if such bradycardia recurs
- Woman of child bearing age should us effective contraception
- Woman breast feeding an infant or child should stop breast feeding
- Male with a female partner of child bearing age should use effective contraception
- The absolute bioavailability of Alecensa is 37% under fed conditions

Criteria:

- **Criteria for initial therapy:** of Alecensa (alectinib) 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 anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC)
  4. **ALL** of the following baseline tests have been completed before initiation of treatment:
     - Liver enzyme tests (alanine transaminase (ALT), aspartate transaminase (AST), and total bilirubin)

  Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Alecensa (alectinib) 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
     - Worsening is defined as:
       - Cancer progression
  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

ALECENSA® (alectinib) oral capsule (cont.)

- Significant adverse effects include:
  - Hepatotoxicity
    - Signs and symptoms may include: right sided abdominal pain, bruising, yellow skin or eyes, dark brown urine, severe nausea or vomiting, fatigue, light colored pale stools, itching, confusion
  - Interstitial lung disease/Pneumonitis
    - Signs and symptoms may include: fever, chest pain or tightness, palpitations, tachycardia, shortness of breath at rest dyspnea on exertion, dry cough, fatigue, weakness
  - Renal impairment
    - Signs and symptoms may include: decreased urine output, abdominal discomfort, muscle cramps or spasms, muscle tetany, change in mentation, weakness, fatigue, nausea, swelling of feet, rapid weight gain
  - Bradycardia
    - Signs and symptoms may include: dizziness, lightheaded, feeling faint or fainting episodes, abnormal slow pulse or heart beat

5. There are no significant interacting drugs

Renewal duration: 12 months

Resources:

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.

Alecensa. Package Insert. Revised by manufacturer 11/2017. Accessed 12-24-2017.

Alecensa. Package Insert. Revised by manufacturer 11/2016. Accessed 11-09-2017.

Alecensa. Package Insert. Revised by manufacturer 12/2015 Accessed 12-30-2015.

Alecensa. Package Insert. Revised by manufacturer 11/2016 Accessed 11-29-2016.

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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

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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.