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

PHARMACY COVERAGE GUIDELINES	**ORIGINAL EFFECTIVE DATE: 3/17/16**
SECTION: DRUGS	**LAST REVIEW DATE: 3/15/18**
	LAST CRITERIA REVISION DATE: 3/15/18
	ARCHIVE DATE:

TYKERB® (lapatinib) oral 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.**

TYKERB® (lapatinib) oral tablet (cont.)

Description:

Tykerb (lapatinib) is indicated in combination with capecitabine for the treatment of patients with advanced or metastatic breast cancer whose tumors overexpress human epidermal receptor type 2 (HER2) and who have received prior therapy including an anthracycline, a taxane, and trastuzumab; and in combination with letrozole for the treatment of postmenopausal women with hormone receptor-positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated.

Patients should have disease progression on trastuzumab prior to initiation of treatment with Tykerb (lapatinib) in combination with capecitabine. Tykerb (lapatinib) in combination with an aromatase inhibitor has not been compared to a trastuzumab-containing chemotherapy regimen for the treatment of metastatic breast cancer.

Tykerb (lapatinib) is a kinase inhibitor of both epidermal growth factor receptor (EGFR) and of HER2 receptors. Lapatinib inhibits tumor cell growth *in vitro* and in various animal models.

Tykerb (lapatinib)

Medication class:
Antineoplastic – Kinase Inhibitor

FDA-approved indication(s):
- In combination with capecitabine, for the treatment of patients with advanced or metastatic breast cancer whose tumors overexpress human epidermal growth factor receptor 2 (HER2) and who have received prior therapy including an anthracycline, a taxane, and trastuzumab
- In combination with letrozole for the treatment of postmenopausal women with hormone receptor-positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated
- Tykerb in combination with an aromatase inhibitor has not been compared to a trastuzumab-containing chemotherapy regimen for the treatment of metastatic breast cancer

Limitations of Use:
- Patients should have disease progression on trastuzumab prior to initiation of treatment with lapatinib in combination with capecitabine

Recommended Dose:
- Advanced or metastatic breast cancer:
  - 1,250 mg (5 tablets) once daily on Days 1-21 continuously in combination with
  - Capecitabine 2,000 mg/m^2/day (given in 2 doses 12 hours apart) on Days 1-14 in a repeating 21-day cycle
- Hormone receptor-positive, HER2-positive metastatic breast cancer:
  - 1,500 mg (6 tablets) once daily continuously in combination with
  - Letrozole 2.5 mg once daily
- Dividing the daily dose of Tykerb is not recommended

Maximum dosage
- Not stated

TYKERB® (lapatinib) oral tablet (cont.)

Available Dosage Forms:
- Tablet: 250 mg

Warnings, Precautions, and other Clinical Information:
- Tykerb should be discontinued in patients with a decreased LVEF that is Grade 2 or greater and in patients with an LVEF that drops below the institution's lower limit of normal (LLN)
- Patients with severe hepatic impairment (Child-Pugh Class C) should have the dose of Tykerb reduced
- Discontinue and do not restart Tykerb if patients experience severe changes in liver function tests
- Tykerb should be permanently discontinued in patients with Grade 4 diarrhea
- Discontinue Tykerb if patients experience severe pulmonary symptoms associated with interstitial lung disease and pneumonitis
- Discontinue Tykerb if life-threatening cutaneous reactions such as erythema multiforme, Stevens-Johnson syndrome, or toxic epidermal necrolysis are suspected
- Woman of child bearing potential should be warned against becoming pregnant
- Woman who is breast feeding an infant or child should stop breast feeding
- Avoid strong CYP3A4 inhibitors, if unavoidable, consider Tykerb dose reduction
- Avoid strong CYP3A4 inducers, if unavoidable, consider Tykerb dose increase
- Absorption of Tykerb is incomplete and variable

Criteria:

- **Criteria for initial therapy**: Tykerb (lapatinib) 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 advanced or metastatic breast cancer

  4. Tykerb (lapatinib) used in combination with **EITHER** of the following:
     - **Capecitabine**, for the treatment of patients with advanced or metastatic breast cancer
       - Whose tumors overexpress HER2 and
       - Who have received prior therapy including an anthracycline, a taxane, and trastuzumab **and**
       - Have disease progression on trastuzumab
     - **Letrozole**, for the treatment of postmenopausal women with hormone receptor-positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated

  5. **ALL** of the following baseline tests have been completed before initiation of treatment:
     - Liver function tests (transaminases, bilirubin, and alkaline phosphatase)
     - Left ventricular ejection fraction (LVEF) evaluation using an echocardiogram, multi-gated acquisition scan, or other appropriate test

TYKERB® (lapatinib) oral tablet (cont.)

6. There are **NO** contraindications.
    - Contraindications include:
        - Known severe hypersensitivity (e.g., anaphylaxis) to Tykerb or any of its components

Initial approval duration: 6 months

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

1. Individual continues to be in consultation with 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 contraindications or other significant level 4 adverse drug effects that may exclude continued use
    - Contraindications as listed in the criteria for initial therapy section
    - Significant adverse effect such as:
        - A decrease in left ventricular ejection fraction below the institution's normal limits
        - Hepatic impairment
        - Severe diarrhea requiring oral or intravenous electrolytes and fluids, use of antibiotics, and interruption or discontinuation of therapy
        - Interstitial lung disease or pneumonitis
        - Cutaneous reactions such as erythema multiforme, Stevens-Johnson syndrome, or toxic epidermal necrolysis
5. There are no significant interacting drugs

Renewal duration: 6 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.

Tykerb. Package Insert. Revised by manufacturer 04/2017. Accessed 02-28-18.

Tykerb. Package Insert. Revised by manufacturer 03/2015. Accessed 03-17-2016, 02-14-17.

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.