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

PHARMACY COVERAGE GUIDELINES	
SECTION: DRUGS	
ORIGINAL EFFECTIVE DATE:	**1/01/16**
LAST REVIEW DATE:	**9/20/18**
LAST CRITERIA REVISION DATE:	**9/20/18**
ARCHIVE DATE:	

ZYKADIA™ (ceritinib) 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.**

ZYKADIA™ (ceritinib) oral capsule (cont.)

Criteria:

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

  1. Provider is an Oncologist

  2. Individual is 18 years of age or older

  3. A confirmed diagnosis of **ONE** of the following:
     - Metastatic non-small cell lung cancer (NSCLC) whose tumor is ALK fusion gene test that is anaplastic lymphoma kinase (ALK)-positive
     - 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, 2A, or 2B

  4. **ALL** of the following baseline tests have been completed before initiation of treatment with continued monitoring as clinically appropriate:
     - Comprehensive metabolic panel
     - Amylase and lipase

  Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Zykadia is considered ***medically necessary*** and will be approved with documentation of **ALL** of the following:

  1. Continues to be seen by an Oncologist

  2. The NSCLC has not progressed 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, such as:
     - Confirmed interstitial lung disease or pneumonitis
     - Life-threatening bradycardia in those who are not taking a medication also known to cause bradycardia or known to cause hypotension
     - QTc interval prolongation such as Torsade de points or polymorphic ventricular tachycardia or signs/symptoms of serious arrhythmia
     - ALT or AST elevation > 3x the upper limit of normal (ULN) with a total bilirubin elevation of > 2x the ULN in the absence of cholestasis or hemolysis
     - Pancreatitis
     - Persistent hyperglycemia (> 250 mg/dL) despite anti-hyperglycemic medications

  5. There are no significant interacting drugs

  Renewal duration: 12 months

ZYKADIA™ (ceritinib) oral capsule (cont.)

Description:

Zykadia (certinib) is a tyrosine kinase inhibitor, indicated for the **treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive** by an FDA-approved test.

Protein kinases (PK) are a group of enzymes that modify other proteins by chemically adding a phosphate group from adenosine triphosphate (ATP) to a target molecule, usually on the serine, threonine, or tyrosine amino acid residues. PK can be subdivided or characterized by the amino acid that is phosphorylated: most PK act on both serine and threonine, tyrosine kinases act on tyrosine, and a number (dual-specificity kinases) act on all three. There are PK that phosphorylate other amino acids, such as histidine kinase that phosphorylates histidine residues. The human genome contains more than 500 PK (the human kinome) that have a role in inflammation, autoimmunity, and metabolism.

Phosphorylation results in a functional change of the target protein which in turn changes enzyme activity, cellular location, or association with other proteins. Processes regulated by phosphorylation include ion transport, cellular proliferation, differentiation, metabolism, migration, cellular survival, and hormone responses. Phosphorylation is a necessary step in some cancers and inflammatory diseases. Inhibition of protein kinase phosphorylation is a pharmacologic target that can be used to treat these disorders.

An inhibitor of protein kinase is a type of enzyme that specifically blocks the action of one or more PK. There are over 20 small molecule protein kinase inhibitors approved for the treatment of various conditions. Several inhibitors have been successfully used to treat human cancers; these agents have been shown to inhibit multiple cellular functions of cancer cells, including proliferation, differentiation, survival, invasion, and angiogenesis.

Protein tyrosine kinases (PTK) play a key role in the regulation of cell proliferation, differentiation, metabolism, migration, and survival. Due to their involvement in various forms of cancers, PTK have become prominent targets for therapy.

Resources:

Zykadia. Package Insert. Revised by manufacturer 12/2017. Accessed 07-19-2018.

Zykadia. Package Insert. Revised by manufacturer 07/2015. Accessed 08-04-2015, 07-22-2016.

NCCN Clinical Practice Guidelines in Oncology: Non-small cell lung cancer. Version 8.2017, Jul 14, 2017. https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf

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.

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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.