RXADVANCE
2 Park Central Drive
Southborough, MA 01772

Clinical Policy Title: **Vemurafenib (Zelboraf)**
Policy Number: **RxA.571**
Drug(s) Applied: **Vemurafenib (Zelboraf®)**
Last Review Date: **01/2020**
Line of Business: **Commercial, HIM, Medicaid**

Background

Vemurafenib (Zelboraf®) is a kinase inhibitor.

Zelboraf is indicated for the treatment of:

- Patients with unresectable or metastatic melanoma with BRAF V600E mutation as detected by an FDA-approved test
- Patients with Erdheim-Chester Disease with BRAF V600 mutation

Limitation(s) of use: Zelboraf is not indicated for treatment of patients with wild-type BRAF melanoma.

Indication	Dosing Regimen	Maximum Dose
Melanoma	960 mg PO BID	1920 mg/day
Erdheim-Chester disease	960 mg PO BID	1920 mg/day

Tablets: 240 mg

Clinical Policy

Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

I. Initial Approval Criteria

A. Melanoma (must meet all)**:**

1. Diagnosis of unresectable or metastatic melanoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. One of the following (a or b):
   a. Positive for a BRAF V600 mutation;
   b. Brain metastasis with a primary diagnosis of melanoma against which Zelboraf was active;

5. Dose does not exceed 1920 mg per day (8 tablets per day).

Approval duration:
Medicaid/HIM – 6 months
Commercial – Length of Benefit

B. Erdheim-Chester Disease (must meet all)**:**

1. Diagnosis of Erdheim-Chester Disease;
2. Prescribed by or in consultation with a hematologist or oncologist;
3. 3. Age ≥ 18 years;

4. Positive for a BRAF V600 mutation;
5. Dose is does not exceed 1920 mg per day (8 tablets per day).

Approval duration:
Medicaid/HIM – 6 months
Commercial – Length of Benefit

C. Non-Small Cell Lung Cancer (off-label) (must meet all)**:**

1. Diagnosis of non-small cell lung cancer (NSCLC);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Positive for a BRAF V600E mutation;
5. Failure of Tafinlar® and Mekinist® unless contraindicated or clinically significant adverse effects are experienced;*
   **Prior authorization may be required.*
6. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:
Medicaid/HIM – 6 months
Commercial – Length of Benefit

D. Hairy Cell Leukemia (off-label) (must meet all)**:**

1. Diagnosis of hairy cell leukemia;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Prescribed as subsequent therapy for relapsed or refractory disease;
5. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:
Medicaid/HIM – 6 months
Commercial – Length of Benefit

E. Thyroid Carcinoma (off-label) (must meet all)**:**

1. Diagnosis of differentiated thyroid carcinoma (i.e., papillary, follicular or Hurthle cell carcinoma);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Positive for a BRAF mutation;
5. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:
Medicaid/HIM – 6 months
Commercial – Length of Benefit

F. Colorectal Cancer (off-label) (must meet all):

1. Diagnosis of colorectal cancer (CRC);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;

4. Positive for a BRAF V600E mutation;
5. Prescribed after failure of irinotecan or platinum-based therapy (e.g., oxaliplatin) and used in combination with irinotecan and either Erbitux® or Vectibix®;*
   **Prior authorization may be required.*
6. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:
Medicaid/HIM – 6 months
Commercial – Length of Benefit

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Currently receiving medication via RxAdvance, or documentation supports that member is currently receiving Zelboraf for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):
   a. New dose does not exceed 1920 mg per day (8 tablets per day);
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:
Medicaid/HIM – 12 months
Commercial – Length of Benefit

III. Appendices

Appendix A: Abbreviation/Acronym Key
CRC: colorectal cancer
FDA: Food and Drug Administration
NSCLC: non-small cell lung cancer

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Tafinlar (dabrafenib)	NSCLC: 150 mg PO QD	300 mg/day
Mekinist (trametinib)	NSCLC: 2 mg PO QD	2 mg/day
irinotecan (Camptosar®)	CRC: Varies	Varies
Erbitux (cetuximab)	CRC: Varies	Varies
Vectibix (panitumumab)	CRC: Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
None reported

References

1. Zelboraf Prescribing information. South San Francisco, CA: Genentech USA, Inc.; October 2018. Available at: www.zelboraf.com. Accessed October 18, 2018.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed October 18, 2018.
3. National Comprehensive Cancer Network. Melanoma Version 3.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/melanoma.pdf. Accessed October 18, 2018.
4. National Comprehensive Cancer Network. Non-Small Cell Lung Cancer Version 6.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed October 18, 2018.
5. National Comprehensive Cancer Network. Hairy Cell Leukemia Version 2.2019. Available at: https://www.nccn.org/professionals/physician_gls/pdf/hairy_cell.pdf. Accessed October 18, 2018.
6. National Comprehensive Cancer Network. Thyroid Carcinoma Version 1.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf. Accessed October 18, 2018.
7. National Comprehensive Cancer Network. Central Nervous System Cancers Version 1.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf. Accessed October 18, 2018.
8. National Comprehensive Cancer Network. Rectal Cancer Version 3.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf. Accessed October 18, 2018. 12. National Comprehensive Cancer Network. Colon Cancer Version 3.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf. Accessed October 18, 2018.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy was established	01/2020	03/06/2020