RXADVANCE
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Southborough, MA 01772

Clinical Policy Title: **Idelalisib (Zydelig)**
Policy Number: **RxA.581**
Drug(s) Applied: **Idelalisib (Zydelig®)**
Last Review Date: **01/2020**
Line of Business: **Commercial, HIM, Medicaid**

Background

Idelalisib (Zydelig®) is a kinase inhibitor.
Zydelig is indicated for the treatment of:

- Relapsed chronic lymphocytic leukemia (CLL), in combination with rituximab, in patients for whom rituximab alone would be considered appropriate therapy due to other co- morbidities
- Relapsed follicular B-cell non-Hodgkin lymphoma (FL) in patients who have received at least two prior systemic therapies*
- Relapsed small lymphocytic lymphoma (SLL) in patients who have received at least two prior systemic therapies*

**Accelerated approval was granted for FL and SLL based on overall response rate. Improvement in patient survival or disease related symptoms has not been established. Continued approval for these indications may be contingent upon verification of clinical benefit in confirmatory trials.*

Limitation(s) of use:

- Zydelig is not indicated and is not recommended for first-line treatment of any patient.
- Zydelig is not indicated and is not recommended in combination with bendamustine and/or rituximab for the treatment of FL.

Indication	Dosing Regimen	Maximum Dose
CLL, FL, SLL	150 mg PO BID	300 mg per day

Tablets: 150 mg, 100 mg

Clinical Policy

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

I. Initial Approval Criteria

A. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (must meet all)**:**

1. Diagnosis of CLL or SLL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Relapsed/refractory disease after ≥ one prior therapy (*see Appendix B for examples*);
   **Prior authorization may be required.*
5. Request meets one of the following (a or b):**
   a. Dose does not exceed 300 mg per day (2 tablets per day);

b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).
***Prescribed regimen must be FDA-approved or recommended by NCCN.*

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

B. Follicular and Marginal Zone Lymphomas (must meet all)**:**

1. One of the following diagnoses (a or b):
   a. FL;
   b. Marginal zone lymphoma (off-label) (i, ii, or iii):
      i. Splenic marginal zone lymphoma;
      ii. Nodal marginal zone lymphoma;
      iii. Extranodal marginal zone lymphoma (a or b):
         a) Gastric MALT lymphoma;
         b) Nongastric MALT lymphoma;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Relapsed/refractory disease after ≥ 2 prior therapies (*see Appendix B for examples*);*
   **Prior authorization may be required.*
5. Request meets one of the following (a or b):**
   a. Dose does not exceed 300 mg per day (2 tablets per day);
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).
   ***Prescribed regimen must be FDA-approved or recommended by NCCN.*

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 benefit, or documentation supports that member is currently receiving Zydelig 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 300 mg per day (2 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*).
   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

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

III. Appendices

Appendix A: Abbreviation/Acronym Key
CLL: chronic lymphocytic leukemia
FDA: Food and Drug Administration

FL: follicular B-cell non-Hodgkin lymphoma
NCCN: National Comprehensive Cancer Network
SLL: small lymphocytic lymphoma

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
CLL/SLL *Examples of first-line, second-line and subsequent therapies:* • FCR (fludarabine, cyclophosphamide, rituximab) • HDMP (high-dose methylprenisolone) + rituximab • Single-agent examples: Imbruvica® (ibrutinib); Venclexta® (venetoclax) ± Gazyva® (obinutuzumab) or rituximab; Campath® (alemtuzumab) ± rituximab; Gazyva; Copiktra® (duvelisib); Calquence® (acalabrutinib); Revlimid® (lenalidomide) ± rituximab; Arzerra® (ofatumumab) ± FC (fludarabine, cyclophosphamide); Leukeran® (chlorambucil) + rituximab	Varies	Varies
Follicular Lymphoma *Examples of first-line, second-line and subsequent therapies:* • bendamustine + Gazyva or rituximab	Varies	Varies
• CHOP (cyclophosphamide, doxorubicin, vincristine, predenisone) + Gazyva or rituximab • CVP (cyclophosphamide, vincristine, prednisone) + Gazyva or rituximab Single-agent examples: rituximab; Revlimid ± rituximab		
Marginal Zone Lymphomas *Examples of first-line, second-line and subsequent therapies:* • bendamustine + rituximab • RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone) • RCVP (rituximab, cyclophosphamide, vincristine, prednisone) Single-agent examples: rituximab; Leukeran ± rituximab; cyclophosphamide ± rituximab; Imbruvica; Revlimid ± rituximab; Copiktra; Aliqopa® (copanlisib)	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

- Contraindication(s): history of serious allergic reactions including anaphylaxis and toxic epidermal

necrolysis
- Boxed warning(s): fatal and serious toxicities - hepatic, severe diarrhea, colitis, pneumonitis, infections, and intestinal perforation

References

1. Zydelig Prescribing Information. Foster City, CA: Gilead Sciences, Inc.; October 2018. Available at http://www.zydelig.com. Accessed August 15, 2019.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed July 22, 2019.
3. National Comprehensive Cancer Network. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma Version 5.2019. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cll.pdf. Accessed July 22, 2019.
4. National Comprehensive Cancer Network. B-cell lymphomas Version 4.2019. Available at www.nccn.org. Accessed July 22, 2019.

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