PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Lorbrena Prior Authorization Policy
- Lorbrena® (lorlatinib tablets – Pfizer)

REVIEW DATE: 11/29/2023

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Lorbrena, a kinase inhibitor, is indicated for the treatment of metastatic **non-small cell lung cancer** (NSCLC) in adults whose tumors are anaplastic lymphoma kinase (*ALK*)-positive as detected by an FDA-approved test.[1]

GUIDELINES

Lorbrena is addressed in National Comprehensive Cancer Network (NCCN) guidelines:[2-5]

- **Histiocytic Neoplasms:** Guidelines (version 1.2023 – August 11, 2023) recommend Lorbrena as a "useful in certain circumstances" treatment option for *ALK*-positive Erdheim-Chester disease (category 2A).[3]
- **NSCLC:** Guidelines (version 5.2023 – November 8, 2023) recommend testing for biomarkers (e.g., *ALK* rearrangement, *ROS* proto-oncogene 1 (*ROS1)* gene rearrangement) in eligible patients with NSCLC.[4]
  - *ALK*-rearrangement-positive NSCLC: If *ALK* rearrangement is discovered prior to first-line systemic therapy, Lorbrena is a preferred first-line treatment option (category 1). If *ALK* rearrangement is discovered during first-line systemic therapy, options are to complete the planned systemic therapy (including maintenance therapy) or to interrupt the systemic therapy and treat with Lorbrena (preferred, category 2A) or another ALK inhibitor. Lorbrena is

also recommended for patients who progress on other *ALK* inhibitors (category 2A).
    - *ROS* proto-oncogene 1 *(ROS1)* rearrangement-positive NSCLC: Lorbrena is a recommended subsequent therapy (category 2A) for patients who progress on Zykadia® (ceritinib capsules and tablets), Xalkori® (crizotinib capsules), or Rozlytrek™ (entrectinib capsules). Lorbrena is not a recommended first-line treatment option for *ROS1* rearrangement-positive NSCLC.
- **Inflammatory Myofibroblastic Tumor (IMT):** NCCN Soft Tissue Sarcoma guidelines (version 2.2023 – April 25, 2023) and NCCN Uterine Neoplasms guidelines (version 1.2023 – December 22, 2022) recommend Lorbrena as a treatment option for IMT with *ALK* translocation.[5,6]

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Lorbrena. All approvals are provided for the duration noted below.

- **Lorbrena® (lorlatinib tablets (Pfizer)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. **Non-Small Cell Lung Cancer – Anaplastic Lymphoma Kinase (*ALK*)-Positive.** Approve for 1 year if the patient meets the following (A, B, C, and D):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has advanced or metastatic disease; AND
   C) Patient has anaplastic lymphoma kinase (*ALK*)-positive disease; AND
   D) The mutation was detected by an approved test.

Other uses With Supportive Evidence

2. **Erdheim-Chester Disease**. Approve for 1 year if the patient meets the following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has anaplastic lymphoma kinase (*ALK*) rearrangement/fusion-positive disease.

3. **Inflammatory Myofibroblastic Tumor.** Approve for 1 year if the patients meets the following (A, B, and C):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has anaplastic lymphoma kinase (*ALK*)-positive disease; AND.
   C) Patient meets one of the following criteria (i or ii):
      i. Patient has advanced, recurrent, or metastatic disease; OR
      ii. The tumor is inoperable.

4. **Non-Small Cell Lung Cancer – *ROS1* Rearrangement-Positive.** Approve for 1 year if the patient meets the following (A, B, C, and D):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has advanced or metastatic disease; AND
   C) Patient has *ROS1* rearrangement-positive disease; AND
   D) Patient has tried at least one of Xalkori (crizotinib capsules), Zykadia (ceritinib capsules or tablets), or Rozlytrek (entrectinib capsules).

CONDITIONS NOT COVERED

Lorbrena® (lorlatinib tablets (Pfizer)
is(are) considered experimental, investigational or unproven for ANY other use(s).

REFERENCES

1. Lorbrena® tablets [prescribing information]. New York, NY: Pfizer; March 2021.
2. The NCCN Drugs & Biologics Compendium. © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on November 27, 2023. Search term: lorlatinib.
3. The NCCN Histiocytic Neoplasms Clinical Practice Guidelines in Oncology (version 1.2023 – August 11, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on November 27, 2023.
4. The NCCN Non-Small Cell Lung Cancer Clinical Practice Guidelines in Oncology (version 5.2023 - November 8, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on November 27, 2023.
5. The NCCN Soft Tissue Sarcoma Clinical Practice Guidelines in Oncology (version 2.2023 – April 25, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on November 27, 2023.
6. The NCCN Uterine Neoplasms Clinical Practice Guidelines in Oncology (version 1.2024 – September 20, 2023) © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on November 27, 2023.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes	11/30/2022
Selected Revision	**Inflammatory Myofibroblastic Tumor:** The requirement that the disease is advanced, recurrent, or metastatic or the tumor inoperable was added.	01/11/2023
Annual Revision	No criteria changes	11/29/2023