PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Nerlynx Prior Authorization Policy
- Nerlynx® (neratinib tablets – Puma)

REVIEW DATE: 06/26/2024

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. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. 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

Nerlynx, a kinase inhibitor, is indicated in adults for the following uses:[1]
- Early-stage human epidermal growth factor receptor 2 (HER2)-positive **breast cancer**, as a single agent for extended adjuvant therapy to follow adjuvant trastuzumab-based therapy.
- Advanced or metastatic HER2-positive **breast cancer**, in combination with capecitabine, for patients who have received two or more prior anti-HER2-based regimens in the metastatic setting.

Guidelines

Nerlynx is discussed in guidelines from the National Comprehensive Cancer Network (NCCN):
- **Breast Cancer:** NCCN guidelines (version 3.2024 – June 17, 2024) note that Nerlynx can be considered as extended adjuvant therapy following adjuvant trastuzumab-containing therapy in patients with hormone receptor (HR)-positive, HER2-positive disease with a perceived high risk of recurrence and node positive (category 2A).[2] The benefits or toxicities associated with extended Nerlynx in patients who have received Perjeta® (pertuzumab intravenous infusion) or Kadcyla® (ado-trastuzumab emtansine intravenous infusion) are unknown. For the treatment of recurrent unresectable (local or regional) or Stage IV or metastatic HER2 positive disease, Nerlynx + capecitabine is recommended for fourth line and beyond setting (category 2A).

- **Central Nervous System Cancers**: NCCN guidelines (version 1.2024 – May 31, 2024) list Nerlynx + capecitabine (category 2A) and Nerlynx + paclitaxel (category 2B) for brain metastases for patients with HER2 positive breast cancer.[3]

POLICY STATEMENT

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

- **Nerlynx® (neratinib tablets (Puma)**

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 Indications

1. **Breast Cancer – Adjuvant Therapy.** Approve for 1 year (total) if the patient meets ALL of the following (A, B, C, and D):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient will not be using this medication in combination with human epidermal growth factor 2 (HER2) antagonists.
     Note: Examples of HER2 antagonists are trastuzumab and Perjeta (pertuzumab intravenous infusion).
   - **C)** Patient has HER2-positive breast cancer; AND
   - **D)** Patient meets ONE of the following (i or ii):
     - **i.** The medication is requested for extended adjuvant therapy after the patient has completed 1 year of adjuvant therapy with a trastuzumab intravenous product; OR
     - **ii.** Patient has tried adjuvant therapy with a trastuzumab intravenous product and could not tolerate 1 year of therapy, according to the prescriber.

2. **Breast Cancer – Recurrent or Metastatic Disease.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has human epidermal growth factor receptor 2 (HER2)-positive breast cancer; AND
   - **C)** The medication is used in combination with capecitabine; AND
   - **D)** Patient has tried at least two prior anti-HER2 based regimens.
     Note: Examples include Perjeta (pertuzumab intravenous infusion) + trastuzumab + docetaxel, Perjeta + trastuzumab + paclitaxel; Enhertu (fam-trastuzumab deruxtecan-nxki intravenous infusion), Kadcyla (ado-trastuzumab emtansine intravenous infusion), Tukysa (tucatinib tablets) + trastuzumab + capecitabine, trastuzumab + capecitabine, lapatinib + capecitabine, trastuzumab + lapatinib.

CONDITIONS NOT COVERED

- **Nerlynx® (neratinib tablets (Puma)**

is(are) considered experimental, investigational, or unproven for ANY other use(s).

REFERENCES

1. Nerlynx® tablets [prescribing information]. Los Angeles, CA: Puma; March 2022.
2. The NCCN Breast Cancer Clinical Practice Guidelines in Oncology (version 3.2024 – June 17, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on June 21, 2024.
3. The NCCN Central Nervous System Cancers Clinical Practice Guidelines in Oncology (version 1.2024 – May 31, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on June 21, 2024

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria change.	10/18/2023
Annual Revision	No criteria change.	06/26/2024