PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Retevmo Prior Authorization Policy
- Retevmo® (selpercatinib capsules – Eli Lilly)

REVIEW DATE: 06/14/2023

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

Retevmo, a kinase inhibitor, is indicated for the following uses:[1]

- **Non-small cell lung cancer**, locally advanced or metastatic with a rearranged during transfection (*RET*) gene fusion, as detected by an FDA-approved test in adults.
- **Solid tumors,** locally advanced or metastatic solid tumors with a *RET* gene fusion in patients who have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options.
- **Thyroid cancer**, advanced or metastatic *RET*-mutant medullary, in patients ≥ 12 years of age who require systemic therapy.
- **Thyroid cancer**, advanced or metastatic *RET* fusion-positive, in patients ≥ 12 years of age who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate), as detected by an FDA-approved test.

All of the indications above except non-small cell lung cancer were accelerated approvals based on overall response rate and duration of response. Continued approval of these indications may be contingent upon verification and description of clinical benefit in confirmatory trials.

Guidelines

Retevmo is addressed in the National Comprehensive Cancer Network (NCCN) compendium for a variety of solid tumors.[2] Retevmo is addressed in NCCN guidelines:

- **Histiocytic Neoplasms:** NCCN guidelines (version 1.2022 – May 20, 2022) recommend Retevmo as an agent that may be useful as the first- or subsequent-line treatment for the following types of histiocytic neoplasm with *RET* fusion: Langerhans cell histiocytosis, Erdheim-Chester disease, and Rosai-Dorfman disease (category 2A).[3]
- **Non-Small Cell Lung Cancer:** NCCN guidelines (version 3.2023 – April 13, 2023) recommend Retevmo as a preferred option for first line and subsequent treatment of patients with *RET* rearrangement-positive recurrent, advanced, or metastatic non-small cell lung cancer (category 2A).[2,4]
- **Thyroid Carcinoma:** NCCN guidelines (version 2.2023 – May 18, 2023) recommend Retevmo and Gavreto® (pralsetinib capsules) as "preferred regimens" for the treatment of *RET* mutation-positive recurrent or persistent locoregional or metastatic medullary carcinoma (category 2A).[5] Retevmo is also recommended for the treatment of locally recurrent, advanced, and/or metastatic *RET*-fusion positive thyroid carcinoma that is not amenable to radioactive iodine therapy as "useful in certain circumstances" (category 2A). Additionally, NCCN recommends Retevmo for *RET*-fusion positive anaplastic thyroid carcinoma for locoregional disease and metastatic disease (category 2A).[5]

POLICY STATEMENT

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

Retevmo® (selpercatinib capsules (Eli Lilly)
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. **Non-Small Cell Lung Cancer.** Approve for 1 year if the patient meets the following criteria (A, B, and C):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has recurrent, advanced, or metastatic disease; AND
   - **C)** The tumor is rearranged during transfection (*RET)* fusion positive.

2. **Thyroid Cancer.** Approve for 1 year if the patient meets the following criteria (A, B, and C):
   - **A)** Patient is ≥ 12 years of age; AND
   - **B)** Patient has rearranged during transfection (*RET)* fusion-positive or *RET* mutation-positive disease; AND
   - **C)** Patient meets ONE of the following criteria (i or ii):
     - **i.** Patient has anaplastic thyroid cancer; OR
     - **ii.** The disease requires treatment with systemic therapy and patient meets ONE of the following criteria (a or b):

a) The patient has medullary thyroid cancer; OR
b) The disease is radioactive iodine-refractory.

3. **Solid Tumors.** Approve for 1 year if the patient meets the following criteria (A, B, and C):
   Note: Examples of solid tumors include breast cancer, cervical cancer, cholangiocarcinoma, colorectal cancer, esophageal cancer, gastric cancer, ovarian cancer, pancreatic adenocarcinoma, salivary gland tumors, soft tissue sarcoma, small bowel adenocarcinoma, and unknown primary cancer.
   A) Patient is ≥ 18 years of age; AND
   B) Patient has recurrent, advanced, or metastatic disease; AND
   C) The tumor is rearranged during transfection (*RET)* fusion positive.

Other Uses with Supportive Evidence

4. **Histiocytic Neoplasm.** Approve for 1 year if the patient meets the following criteria (A, B, and C):
   A) Patient is ≥ 18 years of age; AND
   B) Patient meets one of the following (i, ii, or iii):
      i. Patient has Langerhans cell histiocytosis; OR
      ii. Patient has Erdheim-Chester disease; OR
      iii. Patient has Rosai-Dorfman disease; AND
   C) Patient has a rearranged during transfection (*RET)* fusion.

CONDITIONS NOT COVERED

Retevmo® (selpercatinib capsules (Eli Lilly) is(are) considered experimental, investigational, or unproven for ANY other use(s).

REFERENCES

1. Retevmo® capsules [prescribing information]. Indianapolis, IN: Eli Lilly and Company; September 2022.
2. The NCCN Drugs and Biologics Compendium. © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on June 7, 2023. Search term: selpercatinib.
3. The NCCN Histiocytic Neoplasms Clinical Practice Guidelines in Oncology (version 1.2022 – May 20, 2022). © 2022 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on June 7, 2023.
4. The NCCN Non-Small Cell Lung Cancer Clinical Practice Guidelines in Oncology (version 3.2023 – April 13, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on June 7, 2023.
5. The NCCN Thyroid Carcinoma Clinical Practice Guidelines in Oncology (version 2.2023 – May 18, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on June 7, 2023

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Non-Small Cell Lung Cancer:** The requirement that the patient has metastatic disease was reworded to "advanced, recurrent, or metastatic disease."	06/01/2022

	Thyroid Cancer: The approval condition name was changed from thyroid carcinoma to thyroid cancer. The approval condition of "Medullary Thyroid Carcinoma" was rolled into this approval condition. Based on NCCN guidelines, the qualifier of "advanced or metastatic" disease was removed from the requirement of *RET* positive disease. The qualifier of "if radioactive iodine is appropriate" from "the disease is radioactive iodine-refractory" was removed. Anaplastic thyroid carcinoma was also moved from the Other Uses with Supportive Evidence and into this condition of approval and the age requirement for anaplastic thyroid cancer was changed from ≥ 18 years of age to ≥ 12 years of age. **Histiocytic Neoplasms:** This new condition of approval was added to the policy.	
Selected Revision	**Non-Small Cell Lung Cancer:** The duration of approval was changed from 3 years to 1 year. **Thyroid Cancer:** The duration of approval was changed from 3 years to 1 year. **Histiocytic Neoplasm:** The duration of approval was changed from 3 years to 1 year.	06/22/2022
Selected Revision	**Solid Tumors:** This new condition of approval was added to the policy.	09/28/2022
Selected Revision	**Thyroid Cancer:** "*RET* mutation-positive disease" was added to the criterion, "Patient has rearranged during transfection (*RET*) fusion-positive disease." **Histiocytic Neoplasm:** The types of Langerhans histiocytosis (bone disease, central nervous system lesions, multisystem disease, and pulmonary disease) were removed from the criteria.	10/12/2022
Annual Revision	No criteria changes.	06/14/2023