PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Tasigna Prior Authorization Policy
- Tasigna® (nilotinib capsules – Novartis)

REVIEW DATE: 05/01/2024; selected revision 06/12/2024

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

Tasigna, a tyrosine kinase inhibitor (TKI), is indicated for the following uses:[1]
- **Chronic myeloid leukemia (CML)**, Philadelphia chromosome positive (Ph+), that is newly diagnosed in adult and pediatric patients ≥ 1 year of age in chronic phase.
- **CML**, Ph+, chronic phase and accelerated phase, in adults with resistance or intolerance to prior therapy that included imatinib.
- **CML**, Ph+, chronic phase and accelerated phase, in pediatric patients ≥ 1 year of age with resistance or intolerance to prior TKI therapy.

Guidelines

Tasigna is addressed in guidelines from National Comprehensive Cancer Network (NCCN):
- **Acute Lymphoblastic Leukemia (ALL):** NCCN guidelines for adults and adolescents (version 4.2023 – February 5, 2024) recommend Tasigna for Ph+ disease in many different clinical circumstances (e.g., induction, consolidation therapy, maintenance, or relapsed or refractory disease) [category 2A].[2,8] The guidelines state that the ALL panel considers adolescents to be within the age range of 15-39 years. TKIs in combination with other agents (e.g., chemotherapy or corticosteroids) are recommended for induction therapy for Ph+ ALL. TKIs have also been incorporated into consolidation and maintenance therapy, as well as in the relapsed/refractory setting (category 2A). TKI options include: Bosulif® (bosutinib tablets), Sprycel® (dasatinib tablets), imatinib, Tasigna, or Iclusig® (ponatinib tablets) [category 2A]. NCCN panel notes that not all TKIs have been directly studied within the context of

each specific regimen and there are limited data for Bosulif in Ph+ ALL. Use of a specific TKI should account for anticipated/prior TKI intolerance and disease-related features. For adults and adolescents, Iclusig has activity against T315I mutations and/or in whom no other TKI is indicated (category 2A).

- **CML:** NCCN guidelines (version 2.2024 – December 5, 2023) recommend Tasigna as a "preferred" primary treatment for newly diagnosed chronic phase Ph+ CML patients with a low-, intermediate-, or high-risk score (category 1).[3,8] Tasigna is also recommended as an alternative TKI treatment (after primary treatment with imatinib, Bosulif® [bosutinib tablets], or Sprycel® [dasatinib tablets]) (category 2A). Tasigna is also recommended in a variety of other situations, including post-allogeneic hematopoietic stem cell transplant (category 2A).
- **Gastrointestinal Stromal Tumor (GIST):** NCCN guidelines (version 1.2024 – March 8, 2024) recommend Tasigna as "useful in certain circumstances" after failure on approved therapies (category 2A).[4] Imatinib is a "preferred" regimen for first-line therapy (category 1) for sensitive mutations (excluding platelet-derived growth factor receptor alpha (*PDGFRA*) exon 18 mutations that are insensitive to imatinib including D842V mutation). Ayvakit® (avapritinib tablets) is also a "preferred" regimen (category 2A) for GIST with *PDGFRA* exon 18 mutations that are insensitive to imatinib, including the *PDGFRA* D842V mutation. Second-line therapies include sunitinib as "preferred" (category 1) or Qinlock® (ripretinib tablets) [for patients intolerant or sunitinib] and Sprycel as "other recommended regimen" (category 2A). Stivarga® (regorafenib tablets) is a "preferred" third-line therapy (category 1). Qinlock® (ripretinib tablets) is a "preferred" fourth-line therapy (category 1).
- **Melanoma: Cutaneous**: NCCN guidelines (version 2.2024 – April 3, 2024) recommend Tasigna as "useful in certain circumstances" for metastatic or unresectable disease with an activating *KIT* mutation as second-line or subsequent therapy for disease progression, intolerance, and/or projected risk of progression with *BRAF*-targeted therapy (category 2A).[5]
- **Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions:** NCCN guidelines (version 1.2024 – December 21, 2023) recommend Tasigna as a "preferred" agent for *ABL1* rearrangements in chronic or blast phase (category 2A).[6] It is also recommended as treatment in combination with ALL- or acute myeloid leukemia-type induction chemotherapy followed by allogeneic hematopoietic stem cell transplantation (HSCT) [if eligible] for lymphoid, myeloid or mixed lineage neoplasms with eosinophilia and *ABL1* rearrangement in blast phase (category 2A).[8]
- **Soft Tissue Sarcomas:** NCCN guidelines (version 1.2024 – April 26, 2024) recommend Tasigna as "useful in certain circumstances" as single-agent therapy for the treatment of pigmented villonodular synovitis/tenosynovial giant cell tumor (category 2A).[7] Turalio® (pexidartinib capsules) is the preferred regimen (category 1) and imatinib is also cited as "useful in certain circumstances" (category 2A).

POLICY STATEMENT

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

- **Tasigna® (nilotinib capsules (Novartis)**

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. **Chronic Myeloid Leukemia.** Approve for 1 year if the patient has Philadelphia chromosome-positive chronic myeloid leukemia.

Other Uses with Supportive Evidence

2. **Acute Lymphoblastic Leukemia.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   A) Patient is ≥ 15 years of age; AND
   B) Patient has Philadelphia chromosome-positive acute lymphoblastic leukemia.

3. **Gastrointestinal Stromal Tumor.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has tried ALL of the following (i, ii, iii, and iv):
      i. Imatinib or Ayvakit (avapritinib tablets); AND
      ii. Sunitinib or Sprycel (dasatinib tablets); AND
      iii. Stivarga (regorafenib tablets); AND
      iv. Qinlock (ripretinib tablets).

4. **Melanoma, Cutaneous.** 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 metastatic or unresectable disease; AND
   C) Patient has an activating *KIT* mutation; AND
   D) Patient has tried at least one systemic regimen.
      Note: Examples of a systemic regimen include: Opdivo (nivolumab intravenous infusion) + Yervoy (ipilimumab intravenous infusion), Opdivo + Opdualag (nivolumab/relatlimab-rmbw intravenous infusion), Keytruda (pembrolizumab intravenous infusion), Opdivo, Tafinlar (dabrafenib capsules and tablets for suspension) + Mekinist (trametinib tablets), Zelboraf (vemurafenib tablets) + Cotellic (cobimetinib tablets), Braftovi (encorafenib capsules) + Mektovi (binimetinib tablets).

5. **Myeloid/Lymphoid Neoplasms with Eosinophilia.** Approve for 1 year if the patient meets the BOTH of following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) The tumor has an *ABL1* rearrangement.

6. **Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor.** Approve for 1 year if the patient meets ONE of the following (A or B):
   A) Patient has tried Turalio (pexidartinib capsules); OR
   B) Patient cannot take Turalio, according to the prescriber.
      Note: Examples of reasons for not being able to take Turalio include patients with elevated liver enzymes or concomitant use of medications that are associated with hepatotoxicity.

CONDITIONS NOT COVERED

- **Tasigna® (nilotinib capsules (Novartis)**

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

REFERENCES

1. Tasigna® capsules [prescribing information]. East Hanover, NJ: Novartis; February 2024.
2. The NCCN Acute Lymphoblastic Leukemia Clinical Practice Guidelines in Oncology (version 4.2023 – February 5, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 29, 2024.
3. The NCCN Chronic Myeloid Leukemia Clinical Practice Guidelines in Oncology (version 2.2024 – December 5, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 29, 2024.
4. The NCCN Gastrointestinal Stromal Tumors Guidelines in Oncology (version 1.2024 – March 8, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 29, 2024.
5. The NCCN Melanoma: Cutaneous Clinical Practice Guidelines in Oncology (version 2.2024 – April 3, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 29, 2024.
6. The NCCN Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions Clinical Practice Guidelines in Oncology (version 1.2024 – December 21, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 29, 2024.
7. The NCCN Soft Tissue Sarcoma Clinical Practice Guidelines in Oncology (version 1.2024 – April 26, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 29, 2024.
8. The NCCN Drugs and Biologics Compendium. © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Search term: nilotinib. Accessed on April 29, 2024.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Acute Lymphoblastic Leukemia:** The criterion requiring trial of at least one other tyrosine kinase inhibitor for Philadelphia chromosome-positive acute lymphoblastic leukemia was removed. **Melanoma, Cutaneous:** This new condition of approval was added to "Other Uses With Supportive Evidence" section based on NCCN guideline recommendations.	05/31/2023
Annual Revision	No criteria changes.	05/01/2024
Selected Revision	**Acute Lymphoblastic Leukemia:** The age requirement was changed from ≥18 years of age to ≥ 15 years of age.	06/12/2024