

## **Clinical Policy: Nintedanib (Ofev)**

Reference Number: CP.PHAR.285

Effective Date: 10.01.16

Last Review Date: 08.18

Line of Business: Commercial, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Nintedanib (Ofev<sup>®</sup>) is a kinase inhibitor.

### **FDA Approved Indication(s)**

Ofev is indicated for the treatment of idiopathic pulmonary fibrosis (IPF).

### **Policy/Criteria**

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

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Ofev is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Idiopathic Pulmonary Fibrosis (must meet all):**

1. Diagnosis of IPF;
2. Prescribed by or in consultation with a pulmonologist;
3. Age  $\geq$  18 years;
4. Dose does not exceed 300 mg/day (2 capsules/day).

**Approval duration: 6 months**

##### **B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

#### **II. Continued Therapy**

##### **A. Idiopathic Pulmonary Fibrosis (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 300 mg/day (2 capsules/day).

**Approval duration: 12 months**

##### **B. Other diagnoses/indications (must meet 1 or 2):**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.  
**Approval duration: Duration of request or 6 months (whichever is less);** or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial and CP.PMN.53 for Medicaid or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

IPF: idiopathic pulmonary fibrosis

NCCN: National Comprehensive Cancer Network

NSCLC: non-small cell lung cancer

*Appendix B: Therapeutic Alternatives*

Not applicable

*Appendix C: Contraindications*

Not applicable

*Appendix D: General Information*

- Existing data for the use of Ofev for non-small cell lung cancer (NSCLC) as a second-line agent show statistically significant improvement in progression free survival, but the clinical significance of the improvement (0.7 months) is questionable. Additionally, there is no significant difference in overall survival in patients treated with Ofev. The National Comprehensive Cancer Network (NCCN) guidelines do not currently mention Ofev as a treatment alternative for NSCLC.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
IPF	150 mg PO BID approximately 12 hours apart (100 mg BID for patients with mild hepatic impairment or management of adverse reactions)	300 mg/day

**VI. Product Availability**

Capsules: 100 mg, 150 mg

**VII. References**

1. Ofev Prescribing Information. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc.; January 2018. Available at [www.ofev.com](http://www.ofev.com). Accessed April 3, 2018.

2. Raghu G, Rochweg B, Yuang Z, et al. An official ATS/ERS/JRS/ALAT clinical practice guideline: treatment of idiopathic pulmonary fibrosis, an update of the 2011 clinical practice guideline. *Am J Respir Crit Care Med.* 2015; 192(2): e3-e19.
3. Raghu G, Collard HR, Egan JJ, et al. An official ATS/ERS/JRS/ALAT statement: idiopathic pulmonary fibrosis: evidence-based guidelines for diagnosis and management. *Am J Respir Crit Care Med.* 2011; 183: 788-824.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy	10.16	10.16
Converted to new template. Safety criteria was applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs.	09.17	10.17
3Q 2018 annual review: policies combined for Centene Medicaid and Commercial lines of business; no significant changes from previously approved corporate policy; Medicaid: removed requirement for high-resolution computed tomography or surgical lung biopsy findings confirming diagnosis; Commercial: added age requirement, approval durations modified from length of benefit to 6/12 months; references reviewed and updated.	05.10.18	08.18

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a

discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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