

Clinical Policy: Olaparib (Lynparza)

Reference Number: CP.PHAR.360

Effective Date: 10.03.17

Last Review Date: 02.19

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

Description

Olaparib (Lynparza[®]) is a poly (ADP-ribose) polymerase (PARP) inhibitor.

FDA Approved Indication(s)

Lynparza is indicated for the:

- Maintenance treatment of adult patients with deleterious or suspected deleterious germline or somatic BRCA-mutated (gBRCAm or sBRCAm) advanced epithelial ovarian, fallopian tube or primary peritoneal cancer who are in complete or partial response to first-line platinum-based chemotherapy. Select patients with gBRCAm advanced epithelial ovarian, fallopian tube or primary peritoneal cancer for therapy based on an FDA-approved companion diagnostic for Lynparza
- Treatment of adult patients with deleterious or suspected deleterious germline BRCA-mutated (gBRCAm) advanced ovarian cancer who have been treated with three or more prior lines of chemotherapy. Select patients for therapy based on an FDA-approved companion diagnostic for Lynparza
- Maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, who are in a complete or partial response to platinum-based chemotherapy
- Treatment of patients with deleterious or suspected deleterious gBRCAm, human epidermal growth factor receptor 2 (HER2)-negative metastatic breast cancer who have previously been treated with chemotherapy in the neoadjuvant, adjuvant or metastatic setting. Patients with hormone receptor (HR)-positive breast cancer should have been treated with a prior endocrine therapy or be considered inappropriate for endocrine treatment. Select patients for therapy based on an FDA-approved companion diagnostic for Lynparza

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[®] that Lynparza is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Ovarian Cancer (must meet all):

1. Diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age \geq 18 years;

4. One of the following (a, b or c):
 - a. Both i and ii:
 - i. Documentation of deleterious or suspected deleterious germline BRCA mutation;
 - ii. Failure of ≥ 3 lines of platinum-based chemotherapy (*see Appendix B*), unless contraindicated or clinically significant adverse effects are experienced;
 - b. Completed ≥ 2 platinum-based chemotherapy regimens and is in a complete or partial response;
 - c. Both i and ii:
 - i. Documentation of deleterious or suspected deleterious germline or somatic BRCA-mutation;
 - ii. Completed a platinum-based chemotherapy regimen and is in a complete or partial response;
5. Request meets one of the following (a or b):
 - a. Dose does not exceed 600 mg per day;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:

Medicaid/HIM – 6 months

Commercial – Length of Benefit

B. Breast Cancer (must meet all):

1. Diagnosis of breast cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease has all of the following characteristics (a, b, and c):
 - a. HER2-negative;
 - b. Mutations in the BRCA genes;
 - c. Metastatic or recurrent;
5. Request meets one of the following (a or b):
 - a. Dose does not exceed 600 mg per day;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:

Medicaid/HIM – 6 months

Commercial – Length of Benefit

C. 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, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all):

1. Currently receiving medication via Centene benefit or documentation supports that member is currently receiving Lynparza for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):
 - a. New dose does not exceed 600 mg per day;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:

Medicaid/HIM – 12 months

Commercial – Length of Benefit

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, HIM.PHAR.21 for health insurance marketplace, 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, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ADP: adenosine diphosphate	HER: human epidermal growth factor receptor 2
AML: acute myeloid leukemia	HR: hormone receptor
BRCA: breast cancer gene	MDS: myelodysplastic syndrome
FDA: Food and Drug Administration	NCCN: National Comprehensive Cancer Network
gBRCAm: mutations in the germline BRCA genes	PARP: poly (ADP-ribose) polymerase

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Ovarian Cancer		
Alimta [®] (pemetrexed)	Various	Varies
Alkeran [®] (melphalan)	Various	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Avastin [®] (bevacizumab)	Various	Varies
carboplatin (Paraplatin [®])	Various	Varies
cisplatin (Platinol-AQ [®])	Various	Varies
cyclophosphamide (Cytosan [®])	Various	Varies
docetaxel (Taxotere [®])	Various	Varies
doxorubicin (Doxil [®] , Adriamycin [®])	Various	Varies
etoposide (Vepesid [®])	Various	Varies
gemcitabine (Gemzar [®])	Various	Varies
ifosfamide (Ifex [®])	Various	Varies
irinotecan (Camptosar [®])	Various	Varies
oxaliplatin (Eloxatin [®])	Various	Varies
topotecan (Hycamtin [®])	Various	Varies
Hexalen [®] (altretamine)	Various	Varies

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information

- NCCN recommended uses (2A):
 - Ovarian cancer: preferred single-agent therapy in patients with BRCA mutated genes for persistent disease or recurrence following three or more lines of therapy.
 - Ovarian cancer: maintenance therapy for patients with platinum-sensitive disease who have completed two or more lines of platinum-based therapy and are in a complete or partial response.
 - Breast cancer: single agent for recurrent or stage IV (M1) HER2-negative, BRCA 1/2-germline mutated disease:
 - With symptomatic visceral disease or visceral crisis, or
 - That is hormone receptor-negative, or hormone receptor-positive and endocrine therapy refractory
- Myelodysplastic syndrome/acute myeloid leukemia (MDS/AML) have been confirmed in patients treated with Lynparza. The majority of the cases (17 of 22) were fatal. If MDS/AML is confirmed, discontinue Lynparza.
- The FDA approved Lynparza with a genetic test called BRACAnalysis CDx, a companion diagnostic that will detect the presence of gBRCAm in blood samples from patients with ovarian cancer. Additional information is available at <http://www.fda.gov/companiondiagnostics>.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Ovarian cancer	300 mg PO BID	600 mg/day
Breast cancer	300 mg PO BID	600 mg/day

VI. Product Availability

Tablets: 100 mg, 150 mg

VII. References

1. Lynparza Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP. December 2018. Available at: <https://www.lynparza.com/>. Accessed January 9, 2019.
2. Olaparib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed January 9, 2019.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created. Added new indication for maintenance treatment of ovarian cancer.	09.08.17	11.17
Add new indication for treatment of gBRCAm, human epidermal growth factor receptor 2 (HER2)-negative metastatic breast cancer.	02.20.18	05.18
4Q 2018 annual review: breast cancer: added NCCN off-label uses and summarized NCCN and FDA-approved uses for improved clarity; all indications: removed language “as detected by an FDA approved test”; references reviewed and updated.	07.05.18	11.18
1Q 2019 annual review: Criteria added for new FDA indication for 1 st -line maintenance treatment of gBRCAm or sBRCAm advanced ovarian cancer; removed capsule formulation from policy since it has been discontinued; references reviewed and updated.	01.22.19	02.19

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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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