# Clinical Policy: Olaparib (Lynparza)

Reference Number: CP.PHAR.360
Effective Date: 10.03.17
Last Review Date: 05.18
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 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.
- For the 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
- For the 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.*

**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 ≥ 18 years;
4. One of the following (a or b):
   a. Both i and ii:
      i. Documentation of deleterious or suspected deleterious germline BRCA-mutation as detected by an FDA-approved test (e.g., BRACAnalysis CDx);
      ii. Failure of ≥ 3 lines of 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;
5. Dose does not exceed (a or b):

a. Capsules: 800 mg/day;
b. Tablets: 600 mg/day.

**Approval duration:**
**Medicaid/HIM** – 6 months
**Commercial** – Length of benefit

**B. Breast Cancer** (must meet all)**:**
1. Diagnosis of metastatic breast cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Documentation of human epidermal growth factor receptor 2 (HER2)-negative disease;
5. Mutations in the BRCA genes as detected by an FDA-approved test (e.g., BRACAnalysis CDx);
6. Failure of first line chemotherapy unless contraindicated or clinically significant adverse effects are experienced;
7. If HR positive, failure of endocrine therapy unless contraindicated or clinically significant adverse effects are experienced;
8. Dose does not exceed 600 mg/day (tablets only).

**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 Indication 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, new dose does not exceed (a or b):
   a. Capsules: 800 mg/day;
   b. Tablets: 600 mg/day.

**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
AML: acute myeloid leukemia
BRCA: breast cancer gene
FDA: Food and Drug Administration
gBRCAm: mutations in the germline BRCA genes
HER: human epidermal growth factor receptor 2
HR: hormone receptor
MDS: myelodysplastic syndrome
NCCN: National Comprehensive Cancer Network
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 | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| **Ovarian Cancer** | | |
| Alimta® (pemetrexed) | Various | Varies |
| Alkeran® (melphalan) | Various | Varies |
| Avastin® (bevacizumab) | Various | Varies |
| carboplatin (Paraplatin®) | Various | Varies |
| cisplatin (Platinol-AQ®) | Various | Varies |
| cyclophosphamide (Cytoxan®) | 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 |

| Drug | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| **Breast Cancer** | | |
| paclitaxel (Abraxane®, NovOnxol®, Taxol®) | Various | Varies |
| capecitabine (Xeloda®) | Various | Varies |
| eribulin (Havalen®) | Various | Varies |
| vinorelbine (Navelbine®) | 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: General Information*

- NCCN-recommended use:
  - Preferred single-agent therapy in patients with BRCA mutated genes for persistent disease or recurrence following three or more lines of therapy.
  - 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.
- 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 mutations in the BRCA genes (gBRCAm) in blood samples from patients with ovarian cancer. It is available at http://www.fda.gov/companiondiagnostics.

## V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| Ovarian cancer | Capsules: 400 mg PO BID<br>Tablets: 300 mg PO BID* | Capsules: 800 mg/day<br>Tablets: 600 mg/day |
| Breast cancer | Tablets: 300 mg PO BID* | Tablets: 600 mg/day |

*** Do not** substitute tablets with capsules on a mg-to-mg basis due to differences in the dosing and bioavailability of each formulation.

## VI. Product Availability

- Capsules: 50 mg
- Tablets: 100 mg, 150 mg

## VII. References

1. Lynparza Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP. January 2018. Available at https://www.lynparza.com/. Accessed January 24, 2018.
2. National Comprehensive Cancer Network. Ovarian Cancer Version 3.2017. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ovarian.pdf. Accessed September 8, 2017.
3. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Truven Health Analytics. Updated periodically. Accessed February 28, 2018.

4. National Comprehensive Cancer Network. Breast Cancer Version 3.2017. Available at: https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed January 24, 2018.

| 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 |

**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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**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.