

Clinical Policy: Neratinib (Nerlynx)

Reference Number: CP.PHAR.365

Effective Date: 09.05.17

Last Review Date: 11.18

Line of Business: Commercial, Medicaid

[Revision Log](#)

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

Description

Neratinib (Nerlynx[®]) is a kinase inhibitor that irreversibly binds to epidermal growth factor receptor, human epidermal growth factor receptor 2 (HER2), and HER4.

FDA Approved Indication

Nerlynx is indicated for the extended adjuvant treatment of adult patients with early stage HER2-overexpressed/amplified breast cancer, to follow adjuvant trastuzumab-based therapy.

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 Nerlynx is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Breast Cancer** (member meets all):

1. Diagnosis of breast cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age \geq 18 years;
4. Disease is HER2-positive;
5. Member meets one of the following (a or b):
 - a. Both (i and ii):
 - i. Documentation of previous adjuvant treatment with trastuzumab;
 - ii. Disease is early stage (stage 1-3) or hormone-receptor positive;
 - b. Prescribed in combination with capecitabine for recurrent brain metastases (off-label);
6. Request meets one of the following (a or b):
 - a. Dose does not exceed 240 mg per day (6 tablets 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: 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. Breast Cancer (member meets all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Nerlynx for breast cancer 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 240 mg per day (6 tablets per day);
 - b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months

B. Other diagnoses/indications (member meets 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

HER: human epidermal growth factor receptor

NCCN: National Comprehensive Cancer Network

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 for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Herceptin [®] (trastuzumab) Ogivri [™] (trastuzumab- dkst)	<ul style="list-style-type: none"> • Initial dose of 4 mg/kg IV, then 2 mg/kg IV weekly for 12 weeks (with paclitaxel or docetaxel) or 18 weeks (with docetaxel/carboplatin). One week after the last weekly dose, administer 6 mg/kg IV every 3 weeks to complete a total of 52 weeks of therapy OR	See regimen

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	<ul style="list-style-type: none"> Initial dose of 8 mg/kg IV, then 6 mg/kg IV every 3 weeks for 52 weeks 	

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

- Per the Nerlynx prescribing information, antidiarrheal prophylaxis is recommended during the first 2 cycles (56 days) of Nerlynx treatment and should be initiated with the first dose of Nerlynx in order to address the risk of treatment discontinuation due to diarrhea, as was seen in the pivotal ExteNET trial.
- Nerlynx is FDA-approved for a one year total duration of therapy as it was only administered for one year in the pivotal ExteNET trial; however, the NCCN does not recommend any specific length of treatment.
- The NCCN recommends Nerlynx for hormone receptor-positive, HER2-positive breast cancer in patients with a perceived high risk of recurrence. Nerlynx is also recommended for the treatment of recurrent brain metastases in patients with breast cancer in combination with capecitabine (category 2A) or paclitaxel (category 2B).

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Breast cancer	240 mg PO QD	240 mg/day

VI. Product Availability

Tablet: 40 mg

VII. References

- Nerlynx Prescribing Information. Los Angeles, CA: Puma Biotechnology, Inc.; July 2017. Available at: www.nerlynx.com. Accessed July 6, 2018.
- National Comprehensive Cancer Network. Breast Cancer Version 1.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed July 5, 2018.
- National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed July 5, 2018.
- National Comprehensive Cancer Network. Central Nervous System Cancers Version 1.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf. Accessed July 6, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	09.05.17	11.17
Combined Commercial and Medicaid policies.	02.12.18	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2018 annual review: added NCCN off-label uses; added specialist involvement in care; removed restriction for only 1 year of total therapy as NCCN does not recommend a specific duration of use; references reviewed and updated.	07.06.18	11.18

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.

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