Clinical Policy: Larotrectinib (Vitrakvi)

Reference Number: CP.PHAR.414
Effective Date: 01.15.18
Last Review Date: 02.21
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Larotrectinib (Vitravki®) is a first-generation selective tropomyosin receptor kinase (TRK) tyrosine kinase inhibitor (TKI).

FDA Approved Indication(s)

Vitrakvi is indicated for the treatment of adult and pediatric patients with solid tumors that:

- Have a neurotrophic receptor tyrosine kinase (*NTRK*) gene fusion without a known acquired resistance mutation,
- Are metastatic or where surgical resection is likely to result in severe morbidity, and
- Have no satisfactory alternative treatments or that have progressed following treatment.

Select patients for therapy based on an FDA-approved test. This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

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

I. Initial Approval Criteria

A. NTRK Fusion-Positive Cancer (must meet all)**:**

1. Diagnosis of a solid tumor *(see Appendix D for examples)*:
2. Prescribed by or in consultation with an oncologist;
3. For Vitrakvi request, medical justification supports inability to use larotrectinib, if available, (e.g., contraindications to excipients);
4. Tumor is positive for an NTRK-gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1);
5. Confirmation of no known acquired tropomyosin receptor kinase resistance mutation;
6. Disease is recurrent, advanced, metastatic, unresectable, or resectable with adverse functional outcomes;
7. Member must use Rozlytrek™*, unless contraindicated or clinically significant adverse effects are experienced;
   **Prior authorization may be required.*

8. For disease relapse or progression following Rozlytrek therapy, medical justification as to why additional NTRK targeted therapy is warranted;
9. Request meets one of the following (a, b, or c):*
   a. Adults and pediatric members with body surface area ≥ 1.0 m^2: Dose does not exceed 200 mg per day;
   b. Pediatric members with body surface area < 1.0 m^2: Dose does not exceed 200 mg/m^2 per day;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

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

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, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. NTRK-Fusion Positive Cancer (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Vitrakvi for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Vitrakvi request, medical justification supports inability to use larotrectinib, if available, (e.g., contraindications to excipients);
4. If request is for a dose increase, request meets one of the following (a, b, c):*
   a. Adults and pediatric members with body surface area ≥ 1.0 m^2: New dose does not exceed 200 mg per day;
   b. Pediatric members with body surface area < 1.0 m^2: New dose does not exceed 200 mg/m^2 per day;
   c. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

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.PA.154 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.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

B. Known acquired tropomyosin receptor kinase resistance mutation.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
NCCN: National Comprehensive Cancer Network
NTRK: neurotrophic receptor tyrosine kinase
TKI: tyrosine kinase inhibitor
TRK: tropomyosin receptor kinase

Appendix B: Therapeutic Alternatives

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Rozlytrek (entrectinib)	NTRK fusion-positive solid tumor Adults: 600 mg PO QD Pediatrics (≥ 12 years of age) by body surface area (BSA): • BSA > 1.50 m^2: 600 mg PO QD • BSA 1.11 to 1.50 m^2: 500 mg PO QD • BSA 0.91 to 1.10 m^2: 400 mg PO QD	600 mg/day

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: Examples of Solid Tumors

(Examples are drawn from the Vitrakvi pivotal trials, as described in the FDA prescribing information, as well as the National Comprehensive Center Network (NCCN) Vitrakvi compendium.)

- Breast cancer
- Cancer of the appendix
- Cervical cancer
- Cholangiocarcinoma
- Colorectal cancer
- Epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer
- Lung cancer
- Melanoma
- Pancreatic cancer
- Salivary gland tumor

- Small bowel adenocarcinoma
- Soft tissue sarcoma (e.g., extremity/body wall, head/neck, retroperitoneal/intraabdominal, solitary fibrous tumor, infantile fibrosarcoma, gastrointestinal stromal tumor)
- Thyroid carcinoma (papillary, Hurthle cell, anaplastic, or follicular histology)

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
NTRK fusion-positive solid tumors	• Adult and pediatric patients with body surface area ≥ 1.0 m^2: 100 mg PO BID until disease progression or until unacceptable toxicity • Pediatric patients with body surface area < 1.0 m^2: 100 mg/m^2 PO BID until disease progression or until unacceptable toxicity	200 mg/day

VI. Product Availability

- Capsules: 25 mg, 100 mg
- Oral solution (100 mL bottle): 20 mg/mL

VII. References

1. Vitrakvi Prescribing Information. Stamford, CT: Loxo Oncology, Inc.; March 2021. Available at: www.vitrakvi.com. Accessed April 8, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed November 14, 2020.
3. Drilon A, Laetsch TW, Kummar S, et al. Efficay of larotrectinib in TRK fusion-positive cancers in adults and children. N Eng J Med 2018;378:731-9. DOI:10,1056/NEJMoa1714448.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01.15.18	02.19
No significant changes; finalized line of business to apply to HIM.	04.22.19	
1Q 2020 annual review: removed HIM disclaimer for HIM NF drugs; criteria adjusted to accommodate NCCN recommended uses; references reviewed and updated.	11.19.19	02.20
Added redirection to Rozlytrek per August SDC and prior clinical guidance.	08.19.20	
1Q 2021 annual review: oral oncology generic redirection language added; tumor subtype and subsequent therapy restrictions removed per NCCN; kinase resistance mutation confirmation added/if known, exclusion added (Section III); references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	11.14.20	02.21
RT4: updated FDA indication to include additional language for use of a FDA-approved test.	04.08.21	

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.