

## Clinical Policy: Panitumumab (Vectibix)

Reference Number: LA.PHAR.321

Effective Date:

Last Review Date: 06.26.23

Line of Business: Medicaid

[Coding Implications](#)

[Revision Log](#)

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

**\*\*Please note: This policy is for medical benefit\*\***

### Description

Panitumumab (Vectibix<sup>®</sup>) is an epidermal growth factor receptor (EGFR) antagonist.

### FDA Approved Indication(s)

Vectibix is indicated for the treatment of patients with wild-type *RAS* (defined as wild-type in both *KRAS* and *NRAS* as determined by an FDA-approved test for this use) metastatic colorectal cancer (CRC):

- In combination with FOLFOX for first-line treatment
- As monotherapy following disease progression after prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy

Limitation(s) of use: Vectibix is not indicated for the treatment of patients with *RAS*-mutant metastatic CRC or for whom *RAS* mutation status is unknown.

### 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 Louisiana Healthcare Connections<sup>®</sup> that Vectibix is **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Colorectal Cancer (must meet all):

1. Diagnosis of advanced, recurrent, or metastatic CRC;
2. Prescribed by or in consultation with an oncologist;
3. Age  $\geq$  18 years;
4. Disease is one of the following (a, b, or c):
  - a. Wild-type *RAS* (defined as wild-type in both *KRAS* and *NRAS*);
  - b. BRAF wild-type;
  - c. BRAF V600E mutation positive;
5. One of the following (a, b, or c)\*:
  - a. Request is for first-line treatment: Prescribed in combination with FOLFOX or FOLFIRI (off-label);

- b. Request is for subsequent line treatment: Prescribed as a single agent, in combination with FOLFIRI or FOLFOX, or in combination with irinotecan (off-label);
  - c. Request is for BRAF V600E mutation positive disease: Prescribed in combination with Braftovi® (off-label);  
*\*Prior authorization may be required.*
6. Request meets one of the following (a or b):\*
- a. Dose does not exceed 6 mg/kg every 14 days;
  - b. 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: 6 months**

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

- 1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
- 2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53

**II. Continued Therapy**

**A. Colorectal Cancer (must meet all):**

- 1. Currently receiving medication via Louisiana Healthcare Connections benefit or documentation supports that member is currently receiving Vectibix 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 6 mg/kg every 14 days;
  - b. 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: 12 months**

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

- 1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one LA.PMN.255
- 2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53

**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 policy LA.PMN.53

#### IV. Appendices/General Information

##### *Appendix A: Abbreviation/Acronym Key*

CRC: colorectal cancer

EGFR: epidermal growth factor receptor

FDA: Food and Drug Administration

FOLFIRI: fluorouracil, leucovorin,  
irinotecan

FOLFOX: fluorouracil, leucovorin,  
oxaliplatin

KRAS: Kirsten rat sarcoma 2 viral  
oncogene homologue

CRC: colorectal cancer

FOLFOXIRI: fluorouracil, leucovorin,  
oxaliplatin, irinotecan

NRAS: neuroblastoma RAS viral oncogene  
homologue

##### *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
Modified FOLFOX 6	Day 1: oxaliplatin 85 mg/m <sup>2</sup> IV Day 1: Folinic acid 400 mg/m <sup>2</sup> IV Days 1–3: 5-FU 400 mg/m <sup>2</sup> IV bolus on day 1, then 1,200 mg/m <sup>2</sup> /day × 2 days (total 2,400 mg/m <sup>2</sup> over 46–48 hours) IV continuous infusion Repeat cycle every 2 weeks.	See dosing regimen
CapeOX	Day 1: Oxaliplatin 130 mg/m <sup>2</sup> IV Days 1–14: Capecitabine 1,000 mg/m <sup>2</sup> PO BID Repeat cycle every 3 weeks.	See dosing regimen
FOLFIRI	Day 1: Irinotecan 180 mg/m <sup>2</sup> IV Day 1: Leucovorin 400 mg/m <sup>2</sup> IV Day 1: Flurouracil 400 mg/m <sup>2</sup> IV followed by 2,400 mg/m <sup>2</sup> continuous IV over 46 hours Repeat cycle every 14 days.	See dosing regimen
FOLFOXIRI	Day 1: Irinotecan 165 mg/m <sup>2</sup> IV, oxaliplatin 85 mg/m <sup>2</sup> IV, leucovorin 400 mg/m <sup>2</sup> IV, flurouracil 1,600 mg/m <sup>2</sup> continuous IV for 2 days (total 3,200 mg/m <sup>2</sup> ) Repeat cycle every 2 weeks.	See dosing regimen
Braftovi (Encorafenib)	300 mg PO once daily in combination with panitumumab (6 mg/kg IV every 14 days) until disease progression or unacceptable toxicity.	450 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*

- Contraindication(s): none reported
- Boxed warning(s): dermatologic toxicity

#### V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CRC	6 mg/kg IV over 60 minutes ( $\leq 1,000$ mg) or 90 minutes ( $> 1,000$ mg) every 14 days	6 mg/kg

## VI. Product Availability

Single-dose vial for injection: 100 mg/5 mL, 400 mg/20 mL

## VII. References

1. Vectibix Prescribing Information. Thousand Oaks, CA: Amgen, Inc.; August 2021. Available at <https://www.vectibix.com/>. Accessed August 9, 2022.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: [http://www.nccn.org/professionals/drug\\_compendium](http://www.nccn.org/professionals/drug_compendium). Accessed August 9, 2022.
3. National Comprehensive Cancer Network. Colon Cancer Version 1.2022. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/colon.pdf](https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf). Accessed August 9, 2022.

## Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPSC Codes	Description
J9303	Injection, panitumumab, 10 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted corporate policy to local policy	06.26.23	

## 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. LHCC 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.

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