Clinical Policy: Sacituzumab Govitecan-hziy (Trodelvy)

Reference Number: LA.PHAR.475
Effective Date:
Last Review Date: 07.21.23~~05.01.23~~ Coding Implications
Line of Business: Medicaid 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

Sacituzumab govitecan-hziy (Trodelvy™~~)~~®) is a Trop-2-directed antibody and topoisomerase inhibitor conjugate.

FDA Approved Indication(s)

Trodelvy is indicated for the treatment of adult patients with

- Unresectable locally advanced or metastatic triple-negative breast cancer (mTNBC) who have received two or more prior systemic therapies, at least one of them for metastatic disease
- Unresectable locally advanced or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative (IHC 0, IHC 1+ or IHC 2+/ISH-) breast cancer who have received endocrine-based therapy and at least two additional systemic therapies in the metastatic setting
- Locally advanced or metastatic urothelial cancer (mUC) who have previously received a platinum-containing chemotherapy and either programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PDL1) inhibitor~~.~~**

**This indication is approved under accelerated approval based on tumor response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.*

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® that Trodelvy is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of unresectable or metastatic breast cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Documentation of ~~triple~~one of the following (a or b):
   a. Triple negative (i.e., estrogen receptor-, progesterone receptor-, and human epidermal growth factor receptor 2 [HER2]-negative) disease;

b. Hormone receptor (HR)-positive, HER2-negative disease;

~~4.~~5. Failure of ~~both~~all of the following (a, b, and ~~b~~c):
   a. Two or more prior regimens (*see Appendix B*);
   b. At least one of the prior regimens administered for metastatic disease (*see Appendix B*);
   c. If HR-positive disease, an endocrine based therapy (*see Appendix B);*

~~5.~~6. Prescribed as a single agent;

~~6.~~7. Request meets one of the following (a or b):*
   a. Dose does not exceed 10 mg/kg on days 1 and 8 of each 21-day cycle;
   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. Urothelial Cancer (must meet all)**:**
1. Diagnosis of locally advanced, recurrent, or metastatic urothelial cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Failure of both of the following (a and b):
   a. Platinum-containing chemotherapy (*see Appendix B*);
   b. Programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor (*see Appendix B*);
5. Prescribed as a single agent;
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 10 mg/kg on days 1 and 8 of each 21-day cycle;
   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

C. 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 for the relevant line of business: LA.PMN.53 for Medicaid.

II. Continued Therapy

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

1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Trodelvy 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 10 mg/kg on days 1 and 8 of each 21-day cycle;
   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 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 for the relevant line of business: LA.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 – LA.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
HER2: human epidermal growth factor receptor 2
HR: hormone receptor
mUC: metastatic urothelial cancer
PD-1: programmed death receptor-1
PD-L1: programmed death-ligand
~~TNBC:~~mTNBC: metastatic triple-negative breast cancer

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
Examples of systemic therapies for recurrent unresectable or metastatic breast cancer		
paclitaxel	Varies	Varies
Abraxane® (albumin-bound paclitaxel)	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
docetaxel (Taxotere®)	Varies	Varies
doxorubicin	Varies	Varies
Liposomal doxorubicin (Doxil®)	50 mg/m^2 IV day 1, cycled every 28 days	Varies
capecitabine (Xeloda®)	1,000-1,250 mg/m^2 PO BID on days 1-14, cycled every 21 days	Varies
gemcitabine (Gemzar®)	800-1,200 mg/m^2 IV on days 1,8 and 15, cycled every 28 days	Varies
vinorelbine	Varies	Varies
Halaven® (eribulin)	1.4 mg/m^2 IV on days 1 and 8, cycled every 21 days	Varies
carboplatin	AUC 6 IV on day 1, cycled every 21-28 days	Varies
cisplatin	75 mg/m^2 IV on day 1, cycled every 21 days	Varies
cyclophosphamide	50 mg PO QD on days 1-21, cycled every 28 days	Varies
epirubicin (Ellence®)	60-90 mg/m^2 IV on day 1, cycled every 21 days	Varies
Ixempra® (ixabepilone)	40 mg/m^2 IV on day 1, cycled every 21 days	40 mg/m^2
Examples of platinum-containing regimens for urothelial cancer		
DDMVAC (dose-dense methotrexate, vinblastine, doxorubicin, and cisplatin)	Varies	Varies
gemcitabine with either cisplatin or carboplatin	Varies	Varies
Examples of PD-1 and PD-L1 inhibitors for urothelial cancer		
Keytruda® (pembrolizumab)	Varies	Varies
Tecentriq® (atezolizumab)	Varies	Varies
Opdivo® (nivolumab)	Varies	Varies
Bavencio® (avelumab)	800 mg IV infusion once every 2 weeks	Varies
Examples of endocrine based therapy for breast cancer		
Tamoxifen; aromatase inhibitors: anastrozole (Arimidex®), letrozole (Femara®), exemestane (Aromasin®)	Varies	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

- Contraindication(s): severe hypersensitivity reaction to Trodelvy

- Boxed warning(s): neutropenia and diarrhea

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
~~Triple- negative~~ breast cancer, urothelial cancer	10 mg/kg IV on days 1 and 8 of each 21-day cycle	10 mg/kg

VI. Product Availability

Single-dose vial: 180 mg lyophilized powder for reconstitution

VII. References

1. Trodelvy Prescribing Information. Morris Plains, NJ: Immunomedics, Inc.; ~~October 2021. Available at: https://www.gilead.com/-/media/files/pdfs/medicines/oncology/trodelvy/trodelvy_pi.pdf. Accessed February 13, 2022~~February 2023. Available at: https://www.trodelvyhcp.com/. Accessed July 21, 2023.
2. Bardia A, Mayer IA, Vahdat LT, et al. Sacituzumab Govitecan-hziy in refractory metastatic triple-negative breast cancer. N Engl J Med 2019 Feb 21;380(8):741-51.
3. Sacituzumab govitecan. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. ~~Available at: http://www.nccn.org/professionals/drug_compendium.~~Available at: http://www.nccn.org/professionals/drug_compendium. Accessed February 13, 2022.
4. National Comprehensive Cancer Network Guidelines. Breast Cancer Version 2.2023. Available at https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed February 7, 2023.
5. National Comprehensive Cancer Network Guidelines. Bladder Cancer Version 3.2023. Available at https://www.nccn.org/professionals/physician_gls/pdf/bladder.pdf. Accessed February 7, 2023.

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.

HCPCS Codes	Description
J9317	Injection, sacituzumab govitecan-hziy, 2.5 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Policy created.	05.01.23	
Added new indication for treatment of HR-positive, HER2-negative breast cancer who have received endocrine-based therapy and at least	07.21.23	

Reviews, Revisions, and Approvals	Date	LDH Approval Date
two additional systemic therapies in the metastatic setting. References reviewed and updated.		

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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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 LHCC has no control or right of control. Providers are not agents or employees of LHCC.