Clinical Policy: Ramucirumab (Cyramza)

Reference Number: LA. PHAR.119
Effective Date: 04.21
Last Review Date: 0~~8~~1.22~~1~~
Line of Business: Medicaid

Coding Implications
Revision Log

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

Description
Ramucirumab (Cyramza®) is an anti-vascular endothelial growth factor (VEGF) antibody.

FDA Approved Indication(s)
Cyramza is indicated:

- As a single agent or in combination with paclitaxel, for treatment of advanced gastric or gastro-esophageal junction (i.e., esophagogastric junction; EGJ) adenocarcinoma, with disease progression on or after prior fluoropyrimidine- or platinum-containing chemotherapy.
- In combination with erlotinib, for treatment of metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) mutations.
- In combination with docetaxel, for treatment of metastatic NSCLC with disease progression on or after platinum-based chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving Cyramza.
- In combination with FOLFIRI (irinotecan, folinic acid, and 5-fluorouracil), for the treatment of metastatic colorectal cancer (CRC) with disease progression on or after prior therapy with bevacizumab, oxaliplatin, and a fluoropyrimidine.
- As a single agent, for the treatment of hepatocellular carcinoma (HCC) in patients who have an alpha fetoprotein (AFP) of ≥ 400 ng/mL and have been treated with sorafenib.

Policy/Criteria
Prior authorization is required. *Provider must submit documentation (including 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 Cyramza is medically necessary when the following criteria are met:

I. Initial Approval Criteria

A. Esophageal, Esophagogastric Junction, and Gastric Cancer (must meet all):

1. Diagnosis of advanced esophageal, EGJ or gastric cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed as subsequent therapy in one of the following ways (a, b, or c)*:
   a. As a single agent;
   b. In combination with paclitaxel;

c. In combination with ~~fluorouracil and~~ irinotecan or without fluorouracil;*
**Prior authorization may be required for paclitaxel, fluorouracil or irinotecan.*

5. Disease is unresectable, locally advanced, recurrent, or metastatic;

~~5.~~6. Request meets one of the following (a or b):*
a. Dose does not exceed 8 mg per kg every 2 weeks;
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. Non-Small Cell Lung Cancer (must meet all):
1. Diagnosis of metastatic, recurrent, or advanced NSCLC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Request meets one of the following (a or b):*
   a. Prescribed as subsequent therapy in combination with docetaxel;
   b. Prescribed in combination with erlotinib (Tarceva®);
   **Prior authorization may be required for docetaxel or erlotinib*
5. If prescribed in combination with erlotinib, disease is positive for a sensitizing EGFR mutation (e.g., EGFR exon 19 deletions or exon 21 [L858R] substitution mutation);
6. Request meets one of the following (a, b, or c):*
   a. In combination with docetaxel: dose does not exceed 10 mg/kg on day 1 of a 21-day cycle;
   b. In combination with erlotinib: dose does not exceed 10 mg/kg on day 1 every 2 weeks;
   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: 6 months

C. Colorectal Cancer (must meet all):
1. Diagnosis of advanced or metastatic CRC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed in combination with irinotecan or FOLFIRI (irinotecan, folinic acid, and 5-fluorouracil);*
   **Prior authorization may be required for irinotecan or FOLFIRI.*
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 8 mg/kg every 2 weeks;
   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

D. Hepatocellular Carcinoma (must meet all):
1. Diagnosis of progressive HCC;

2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. AFP ≥ 400 ng/mL;
5. Disease has progressed on or after therapy with Nexavar®;*
   **Prior authorization may be required for Nexavar*
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 8 mg/kg every 2 weeks;
   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

E. Other diagnoses/indications
1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): 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 Cyramza 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, b, c, or d)*:
   a. Esophageal/EGJ/gastric cancer, CRC, HCC: new dose does not exceed 8 mg/kg every 2 weeks;
   b. NSCLC in combination with docetaxel: new dose does not exceed 10 mg/kg on day 1 of a 21-day cycle;
   c. NSCLC in combination with erlotnib: new dose does not exceed 10 mg/kg every 2 weeks;
   d. 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. Currently receiving medication via Louisiana Healthcare Connections 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 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): 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 policy – LA.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AFP: alpha fetoprotein
CRC: colorectal carcinoma
EGJ: esophagogastric junction
EGFR: epidermal growth factor receptor
FDA: Food and Drug Administration
HCC: hepatocellular carcinoma
FOLFIRI: fluorouracil, leucovorin, irinotecan
NCCN: National Comprehensive Cancer Network
NSCLC: non-small cell lung cancer
VEGF: vascular endothelial growth factor

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may require prior authorization.

Drug	Dosing Regimen	Dose Limit/ Maximum Dose
Paclitaxel, irinotecan, 5-FU	Esophageal, EGF, or gastric cancer: Varies	Varies
docetaxel (Taxotere®)	NSCLC: Varies	Varies
Erlotinib (Tarceva)	NSCLC: 150 mg PO QD	150 mg/day
irinotecan (Camptosar®)	CRC: Varies	Varies
FOLFIRI (5-FU, leucovorin, irinotecan)	CRC: Varies	Varies
Nexavar (sorafenib)	HCC: 400 mg PO BID	800 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: Hepatocellular Carcinoma*~~
~~A Cyramza REACH and REACH-2 pivotal trial pooled analysis of 542 patients with disease progression on or after Nexavar and a baseline AFP level of ≥ 400 ng/mL showed that median overall survival was greater for patients who received Cyramza compared to patients who received placebo (8.1 vs 5.0 months, respectively; HR, 0.69; 95% CI, 0.57-0.84; P<0.001). For advanced HCC, Cyramza subsequent-line therapy post-Nexavar therapy in cases where AFP is ≥ 400 ng/mL is consistent with both FDA-approved labeling and NCCN guideline recommendations.~~

~~*National Comprehensive Cancer Network Guidelines. Hepatobiliary Cancers Version 5.2020. Available at nccn.org. Accessed October 14, 2020.*~~

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V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Gastric or EGJ adenocarcinoma, HCC	~~Gastric or EGJ adenocarcinoma, HCC~~ 8 mg/kg IV every 2 weeks as a single agent or in combination with weekly paclitaxel ~~IV~~	8 mg/kg
NSCLC	10 mg/kg IV on day 1 of a 21-day cycle prior to docetaxel 10 mg/kg IV every 2 weeks with daily erlotinib	10 mg/kg
CRC	8 mg/kg every 2 weeks IV prior to FOLFIRI	8 mg/kg
HCC	8 mg/kg IV every 2 weeks	8 mg/kg

VI. Product Availability

Single-dose vial: 100 mg/10 mL (10 mg/mL) solution, 500mg/50mL (10mg/mL) solution

VII. References

1. Cyramza Prescribing Information. Indianapolis, IN: Eli Lilly and Company; June 2021~~0~~. Available at http://uspl.lilly.com/cyramza/cyramza.html. Accessed September~~October~~ 14, 2021~~0~~.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at nccn.org. Accessed September~~October~~ 14, 2021~~0~~
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4. National Comprehensive Cancer Network Guidelines. Gastric Cancer Version ~~4~~3.2021~~0~~. Available at https://www.nccn.org/professionals/physician_gls/pdf/gastric.pdf . ~~nccn.org.~~ Accessed September~~October~~ 14, 2021~~0~~.
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7. National Comprehensive Cancer Network Guidelines. Rectal Cancer Version ~~2~~6.2021~~0~~. Available at https://www.nccn.org/professionals/physician_gls/pdf/rectal.pdf . ~~nccn.org.~~ Accessed September~~October~~ 14, 2021~~0~~.
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Coding Implications

CLINICAL POLICY
Ramucirumab

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
J9308	**Injection, ramucirumab, 5mg**

Reviews, Revisions, and Approvals	Date
Converted corporate to local policy.	01.21
Revised criteria for advanced esophageal, EGJ or gastric cancer allowing combination with irinotecan with or without fluorouracil and added requirement for unresectable, locally advanced, recurrent, or metastatic disease per NCCN; updated Appendix B Therapeutic Alternatives; references reviewed and updated.	**09.22**

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~~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.

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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~~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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