BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINE

IRESSA® (gefitinib) oral

This Pharmacy Coverage Guideline (PCG):
- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively "Service") is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider's judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member's benefit plan; and
- Is subject to change as new information becomes available.

Scope
- This PCG applies to Commercial and Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

Instructions & Guidance
- To determine whether a member is eligible for the Service, read the entire PCG.
- This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
- Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
- The "Criteria" section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member's benefit plan.
- The "Description" section describes the Service.
- The "Definition" section defines certain words, terms or items within the policy and may include tables and charts.
- The "Resources" section lists the information and materials we considered in developing this PCG
- **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
- Information about medications that require precertification is available at www.azblue.com/pharmacy. You must fully complete the request form and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to Pharmacyprecert@azblue.com.

Criteria:

➢ **Criteria for initial therapy:** Iressa (gefitinib) is considered ***medically necessary*** and will be approved when **ALL** the following criteria are met:

1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with an Oncologist.

2. Individual is 18 years of age or older.

3. Individual has a confirmed diagnosis of **ONE** of the following:
    a. Metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions **OR** exon 21 (L858R) substitution mutations as detected by an FDA-approved test

b. Other request for a specific oncologic direct treatment use that is found and listed in the National Comprehensive Cancer Network (NCCN) Guidelines with Categories of Evidence and Consensus of 1 and 2A

4. Eastern Cooperative Oncology Group (ECOG) Performance Status (also known as World Health Organization Performance Status) of 0-2

Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Iressa (gefitinib) is considered ***medically necessary*** and will be approved when **ALL** the following criteria are met **(samples are not considered for continuation of therapy**):

1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with an Oncologist.

2. Individual's condition has responded while on therapy with response defined as **ALL** the following:
   a. No evidence of disease progression
   b. Documented evidence of efficacy, disease stability and/or improvement

3. Individual has been adherent with the medication.

4. Individual has not developed any significant adverse drug effects that may exclude continued use such as:
   a. Confirmed interstitial lung disease
   b. Severe hepatic impairment (Child-Pugh Class C)
   c. Gastrointestinal perforation
   d. Persistent ulcerative keratitis or other severe or worsening ocular disorder
   e. Severe bullous, blistering or exfoliative skin disorder

Renewal duration: 12 months

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. **Off-Label Use of Non-Cancer Medications**

2. **Off-Label Use of Cancer Medications**

Description:

Iressa (gefitinib) is a tyrosine kinase inhibitor indicated for the first line treatment of metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test. The safety and efficacy of Iressa (gefitinib) have not been established in patients with metastatic NSCLC whose tumors have EGFR mutations other than exon 19 deletions or exon 21 (L858R) substitution mutations.

PHARMACY COVERAGE GUIDELINE

IRESSA® (gefitinib) oral

The epidermal growth factor receptor (EGFR) is expressed on the cell surface of both normal and cancer cells and plays a role in the processes of cell growth and proliferation. Some EGFR activating mutations (exon 19 deletion or exon 21 point mutation L858R) within NSCLC cells have been identified as contributing to the promotion of tumor cell growth, blocking of apoptosis, increasing the production of angiogenic factors and facilitating the processes of metastasis.

Gefitinib reversibly inhibits the kinase activity of wild-type and certain activating mutations of EGFR, preventing autophosphorylation of tyrosine residues associated with the receptor, thereby inhibiting further downstream signaling and blocking EGFR-dependent proliferation.

Gefitinib offers a new chemotherapeutic agent with a unique mechanism of action. It is indicated as monotherapy for the treatment of patients with locally advanced or metastatic NSCLC after failure of both platinum-based and docetaxel chemotherapies. The FDA believes that the potential benefit of this agent in these patients outweighs the risk of its pulmonary toxicity, while some special interest groups do not support this decision.

Resources:

Iressa (gefitinib) product information, revised by AstraZeneca Pharmaceuticals, LP 05-2021. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed August 03, 2022.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Non-small cell lung cancer. Version 3.2023 – Updated March 16, 2022. Available at https://www.nccn.org. Accessed August 03, 2022.

Off Label Use of Cancer Medications: A.R.S. §§ 20-826(R) & (S). Subscription contracts; definitions.

Off Label Use of Cancer Medications: A.R.S. §§ 20-1057(V) & (W). Evidence of coverage by health care service organizations; renewability; definitions.