

Clinical Policy: Alpelisib (Piqray)

Reference Number: CP.PHAR.430

Effective Date: 07.09.19

Last Review Date: 08.20

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

Description

Alpelisib (Piqray®) is a phosphoinositide 3-kinase (PI3K) inhibitor.

FDA Approved Indication(s)

Piqray is indicated in combination with fulvestrant for the treatment of postmenopausal women, and men, with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated, advanced or metastatic breast cancer as detected by an FDA-approved test following progression on or after an endocrine-based regimen.

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

I. Initial Approval Criteria**A. Breast Cancer** (must meet all):

1. Diagnosis of breast cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease has all of the following characteristics (a, b, c, and d):
 - a. HR-positive (i.e., estrogen or progesterone receptor [ER/PR]-positive);
 - b. HER2-negative;
 - c. Advanced (locally recurrent) or metastatic;
 - d. Positive for PIK3CA mutation;
5. Piqray is prescribed in combination with fulvestrant;
6. Disease has progressed on or after an endocrine therapy (*see Appendix B for examples*);
7. Request meets one of the following (a or b):*
 - a. Dose does not exceed 300 mg (two tablets) per day;
 - 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:**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.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Breast Cancer (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Piqray for breast cancer 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 300 mg (two tablets) per day;
 - 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:

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 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.PHAR.21 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.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ER: estrogen receptor

FDA: Food and Drug Administration

HER2: human epidermal growth factor
receptor 2

HR: hormone receptor

NCCN: National Comprehensive Cancer
Network

PR: progesterone receptor

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
Endocrine Therapy		
anastrozole (Arimidex [®])	1 mg PO QD	1 mg/day
exemestane (Aromasin [®])	25 mg PO QD	25 mg/day
Fareston [®] (toremifene)	60 mg PO QD	60 mg/day
Faslodex [®] (fulvestrant)	500 mg IM into the buttocks slowly (1 - 2 minutes per injection) as two 5 mL injections, one in each buttock, on days 1, 15, 29 and once monthly thereafter	500 mg/day
letrozole (Femara [®])	2.5 mg PO QD	2.5 mg/day
tamoxifen (Nolvadex [®] , Soltamox [®])	20 to 40 mg PO QD	40 mg/day
megestrol acetate	40 mg PO QID	160 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): severe hypersensitivity to Piqray or to any of its components.
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Breast cancer	In combination with fulvestrant: 300 mg PO QD with food	300 mg/day

VI. Product Availability

Tablets: 50 mg, 150 mg, 200 mg

VII. References

1. Piqray Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; May 2019. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/212526s000lbl.pdf. Accessed April 30, 2020.
2. Micromedex[®] Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed April 30, 2020.
3. National Comprehensive Cancer Network. Breast Cancer Version 3.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed April 30, 2020.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	07.09.19	08.19
Added HIM line of business per SDC and prior clinical guidance.	10.07.19	
3Q2020 annual review: no significant changes; references reviewed and updated.	04.30.20	08.20

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.

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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.

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