Clinical Policy: Avapritinib (Ayvakit)

Reference Number: CP.PHAR.454
Effective Date: 03.01.20
Last Review Date: 02.21
Line of Business: Commercial, HIM, Medicaid Revision Log

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

Description

Avapritinib (Ayvakit™) is a tyrosine kinase inhibitor.

FDA Approved Indication(s)

Ayvakit is indicated for the treatment of adults with unresectable or metastatic gastrointestinal stromal tumor (GIST) harboring a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations.

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

I. Initial Approval Criteria

A. Gastrointestinal Stromal Tumor (must meet all)**:**

1. Diagnosis of unresectable or metastatic GIST;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For Ayvakit request, medical justification supports inability to use avapritinib, if available, (e.g., contraindications to excipients);
5. One of the following (a or b):
   a. Documentation of a PDGFRA exon 18 D842V mutation;
   b. Member meets both of the following (i and ii):
      i. Documentation of a PDGFRA exon 18 mutation other than D842V;
      ii. Failure of imatinib*, unless contraindicated or clinically significant adverse effects are experienced;

      **Prior authorization may be required for imatinib*
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 300 mg (1 tablet) 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. Myeloid/Lymphoid Neoplasm with Eosinophilia and Tyrosine Kinase Fusion Gene (must meet all)**:**

1. Diagnosis of myeloid/lymphoid neoplasm with eosinophilia (MLNE) and FIP1L1-PDGFRA rearrangement;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For Ayvakit request, medical justification supports inability to use avapritinib, if available, (e.g., contraindications to excipients);
5. Member meets both of the following (i and ii):
   a. Documentation of a PDGFRA D842V mutation;
   b. Failure of imatinib*, unless contraindicated or clinically significant adverse effects are experienced;

   **Prior authorization may be required for imatinib*
6. Dose is within FDA maximum limit for any FDA-approved indication or 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

C. 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.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

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

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Ayvakit for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Ayvakit request, medical justification supports inability to use avapritinib, if available, (e.g., contraindications to excipients);
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 300 mg (1 tablet) 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 or 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.PA.154 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.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
GIST: gastrointestinal stromal tumor
MLNE: myeloid/lymphoid neoplasm with eosinophilia
NCCN: National Comprehensive Cancer Network
PDGFR: platelet-derived growth factor 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
imatinib mesylate (Gleevec®)	**GIST** 400 mg PO QD up to 400 mg BID [FDA label] **MLNE** 100-400 mg PO QD [NCCN]	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

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
GIST	300 mg PO QD	300 mg/day

VI. Product Availability

Tablets: 100 mg, 200 mg, 300 mg

VII. References

1. Ayvakit Prescribing Information. Cambridge, MA: Blueprint Medicines Corporation; January 2020. Available at: www.ayvakit.com. Accessed November 5, 2020.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed November 5, 2020.

3. National Comprehensive Cancer Network. Gastrointestinal Stromal Tumors (GISTs) Version 1.2021. Available at: www.nccn.org. Accessed November 5, 2020.
4. National Comprehensive Cancer Network. Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes Version 3.2021. Available at: www.nccn.org. Accessed November 5, 2020.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01.21.20	02.20
1Q 2021 annual review: oral oncology generic redirection language added; NCCN recommended use for myeloid/lymphoid neoplasm added; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	11.05.20	02.21

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.