Clinical Policy: Niraparib (Zejula)
Reference Number: CP.PHAR.408
Effective Date: 05.09.17
Last Review Date: 02.20
Line of Business: Commercial, Medicaid

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

Description
Niraparib (Zejula®) is a poly(ADP-ribose) polymerase (PARP) inhibitor.

FDA Approved Indication(s)
Zejula is indicated for the:
- Maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy
- Treatment of adult patients with advanced ovarian, fallopian tube, or primary peritoneal cancer who have been treated with three or more prior chemotherapy regimens and whose cancer is associated with homologous recombination deficiency (HRD) positive status defined by either:
  - a deleterious or suspected deleterious BRCA mutation, or
  - genomic instability and who have progressed more than six months after response to the last platinum-based chemotherapy.

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 Zejula is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Ovarian Cancer (must meet all):
      1. Diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer;
      2. Prescribed by or in consultation with an oncologist;
      3. Age ≥ 18 years;
      4. One of the following (a or b):
         a. Both i and ii:
            i. Disease is associated with HRD positive status defined by one of the following (1 or 2):
               1) Documentation of deleterious or suspected deleterious germline BRCA mutation;
               2) Documentation of genomic instability and disease has progressed > 6 months after response to the last platinum-based chemotherapy;
ii. Failure of ≥ 3 prior chemotherapy regimens (see Appendix B), unless contraindicated or clinically significant adverse effects are experienced;
b. Completed ≥ 2 platinum-based chemotherapy regimens and is in a complete or partial response;

5. Request meets one of the following (a or b):*
a. Dose does not exceed 300 mg (3 capsules) 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 – 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 and CP.PMN.53 for Medicaid.

II. Continued Therapy
A. Ovarian Cancer (must meet all):
   1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Zejula 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 300 mg (3 capsules) 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 – 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 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 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
- HRD: homologous recombination deficiency
- PARP: poly(ADP-ribose) polymerase

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 and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ovarian Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alimta® (pemetrexed)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>Alkeran® (melphalan)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>Avastin® (bevacizumab)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>carboplatin (Paraplatin®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>cisplatin (Platinol-AQ®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>cyclophosphamide (Cytoxan®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>docetaxel (Taxotere®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>doxorubicin (Doxil®, Adriamycin®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>etoposide (Vepesid®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>gemcitabine (Gemzar®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>ifosfamide (Ifex®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>irinotecan (Camptosar®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>oxaliplatin (Eloxatin®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>topotecan (Hycamtin®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>Hexalen® (altretamine)</td>
<td>Various</td>
<td>Varies</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ovarian, fallopian tube, or primary peritoneal cancer</td>
<td>300 mg PO QD</td>
<td>300 mg/day</td>
</tr>
</tbody>
</table>

VI. Product Availability
Capsules: 100 mg

VII. References

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created. Adopted from CP.CPA.200 Niraparib (Zejula)</td>
<td>11.20.18</td>
<td>02.19</td>
</tr>
<tr>
<td>1Q 2020 annual review: criteria added for expanded FDA-indication in advanced ovarian, fallopian tube, or primary peritoneal cancer after treated with three or more prior chemotherapy regimens and whose cancer is associated with HRD positive status; references reviewed and updated.</td>
<td>11.26.19</td>
<td>02.20</td>
</tr>
</tbody>
</table>

**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.

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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 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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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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