


## PHARMACY / MEDICAL POLICY – 5.01.603

## Epidermal Growth Factor Receptor (EGFR) Inhibitors

Effective Date:	June 1, 2024	RELATED MEDICAL POLICIES:
Last Revised:	May 14, 2024	5.01.517 Use of Vascular Endothelial Growth Factor Receptor (VEGF) Inhibitors and Other Angiogenesis Inhibitors in Oncology Patients
Replaces:	N/A	5.01.518 BCR-ABL Kinase Inhibitors
		5.01.534 Multiple Receptor Tyrosine Kinase Inhibitors
		5.01.544 Prostate Cancer Targeted Therapies
		5.01.549 Off-Label Use of Drugs and Biologic Agents

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## Introduction

Genes contain instructions for how a cell makes proteins. Proteins drive the functions within a cell. The EGFR gene produces a protein called epidermal growth factor, which instructs the cells to grow and divide. Changes to the EGFR gene, however, can result in too much EGFR protein. Too much EGFR protein causes cells to grow uncontrollably, leading to tumors. An EGFR inhibitor is a type of biological therapy that might stop cancer cells from growing. This policy discusses when EGFR inhibitors may be considered medically necessary.

**Note:** The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

## Policy Coverage Criteria

## Small Molecule EGFR Inhibitors

Drug	Medical Necessity
<b>Oral Drugs</b>	
<p><b>Gilotrif (afatinib)</b></p> <p><b>Managed under pharmacy benefit</b></p>	<p><b>Gilotrif (afatinib) may be considered medically necessary for:</b></p> <ul style="list-style-type: none"> <li>• First-line treatment of individuals with metastatic non-small cell lung cancer (NSCLC) whose tumors have non-resistant epidermal growth factor receptor (EGFR)</li> <li>• Treatment of individuals with metastatic, squamous NSCLC progressing after platinum-based (eg, cisplatin, carboplatin, oxaliplatin) chemotherapy</li> </ul> <p><b>Note:</b> Safety and efficacy of Gilotrif were not established in individuals whose tumors have resistant EGFR mutations.</p>
<p><b>Iressa (gefitinib)</b></p> <p><b>Managed under pharmacy benefit</b></p>	<p><b>Iressa (gefitinib) may be considered medically necessary for:</b></p> <ul style="list-style-type: none"> <li>• First-line treatment of individuals with metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>• The individual has tried and failed generic gefitinib</li> </ul> <p><b>Note:</b> Safety and efficacy of Iressa were not established in individuals whose tumors have resistant EGFR mutations.</p>
<p><b>Generic gefitinib</b></p> <p><b>Managed under pharmacy benefit</b></p>	<p><b>Generic gefitinib may be considered medically necessary for:</b></p> <ul style="list-style-type: none"> <li>• First-line treatment of individuals with metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations</li> </ul> <p><b>Note:</b> Safety and efficacy of gefitinib were not established in individuals whose tumors have resistant EGFR mutations.</p>
<p><b>Tagrisso (osimertinib)</b></p> <p><b>Managed under pharmacy benefit</b></p>	<p><b>Tagrisso (osimertinib) may be considered medically necessary for:</b></p> <ul style="list-style-type: none"> <li>• Individual is 18 years or older</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>• Meets one of the following:</li> </ul>



Drug	Medical Necessity
	<ul style="list-style-type: none"> <li>○ Diagnosed with metastatic non-small cell lung cancer (NSCLC) that have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations</li> <li>○ Requires adjuvant therapy after tumor resection in individuals with NSCLC whose tumors have EGFR exon 19 deletions or exon 21 L858R mutations</li> <li>○ Diagnosed with metastatic EGFR <b>T790M mutation-positive</b> NSCLC, whose disease has progressed on or after EGFR tyrosine kinase inhibitor (TKI) therapy (e.g., gefitinib)</li> <li>○ Requires initial treatment with locally advanced or metastatic NSCLC whose tumors have EGFR exon 19 deletions or exon 21 L858R mutations in combination with pemetrexed and platinum-based chemotherapy</li> </ul>
<p><b>Tarceva (erlotinib)</b></p> <p><b>Managed under pharmacy benefit</b></p>	<p><b>Tarceva (erlotinib) may be considered medically necessary for:</b></p> <ul style="list-style-type: none"> <li>• Treatment of individuals with metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations receiving first-line, maintenance, or second or greater line treatment after progression following at least one prior chemotherapy regimen <ul style="list-style-type: none"> <li>○ Tarceva is not recommended for use in combination with platinum-based chemotherapy</li> </ul> </li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• First-line treatment of individuals with locally advanced, unresectable or metastatic pancreatic cancer, in combination with gemcitabine</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>• The individual has tried and failed generic erlotinib</li> </ul> <p><b>Note:</b> Safety and efficacy of Tarceva were not established in individuals with NSCLC whose tumors have other EGFR mutations.</p>
<p><b>Generic erlotinib</b></p> <p><b>Managed under pharmacy benefit</b></p>	<p><b>Generic erlotinib may be considered medically necessary for:</b></p> <ul style="list-style-type: none"> <li>• Treatment of individuals with metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations receiving first-line, maintenance, or</li> </ul>



Drug	Medical Necessity
	<p>second or greater line treatment after progression following at least one prior chemotherapy regimen.</p> <ul style="list-style-type: none"> <li>○ Tarceva is not recommended for use in combination with platinum-based chemotherapy</li> <li>● First-line treatment of individuals with locally advanced, unresectable or metastatic pancreatic cancer, in combination with gemcitabine.</li> </ul> <p><b>Note:</b> Safety and efficacy of erlotinib were not established in individuals with NSCLC whose tumors have other EGFR mutations.</p>
<p><b>Vizimpro (dacomitinib)</b></p> <p><b>Managed under pharmacy benefit</b></p>	<p><b>Vizimpro (dacomitinib) may be considered medically necessary for:</b></p> <ul style="list-style-type: none"> <li>● First-line treatment of individuals with metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations.</li> </ul> <p><b>Note:</b> Safety and efficacy of Vizimpro were not established in individuals whose tumors have resistant EGFR mutations.</p>

**Investigational**

**All other uses of Tarceva (erlotinib), generic erlotinib, generic gefitinib, Gilotrif (afatinib), Iressa (gefitinib), Vizimpro (dacomitinib) and Tagrisso (osimertinib) not listed above are considered investigational.**

### Monoclonal Antibodies to EGFR Receptors

Drug	Medical Necessity
<b>Injectable Drugs</b>	
<p><b>Erbix (cetuximab)</b></p> <p><b>Managed under medical benefit</b></p>	<p><b>Erbix (cetuximab) may be considered medically necessary for:</b></p> <ul style="list-style-type: none"> <li>● The treatment of metastatic colorectal cancer (mCRC) when individual has not had prior Vectibix (panitumumab) therapy and when used:</li> </ul>



Drug	Medical Necessity
	<ul style="list-style-type: none"> <li>○ As a single agent in first or later line of therapy for documented KRAS and NRAS wild-type mCRC</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>○ In combination with the FOLFIRI or FOLFOX regimen in first or later line of therapy for documented KRAS and NRAS wild-type mCRC</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>○ In combination with irinotecan in individuals who are refractory to irinotecan-based chemotherapy for documented KRAS and NRAS wild-type mCRC</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>○ In combination with Braftovi (encorafenib) for mCRC with a BRAF V600E mutation when used after prior therapy</li> </ul> <ul style="list-style-type: none"> <li>• The treatment of locally or regionally advanced squamous cell carcinoma of the head and neck (SCCHN) and when used: <ul style="list-style-type: none"> <li>○ In combination with radiation therapy</li> </ul> </li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>○ As a single agent in individuals with prior radiation therapy for SCCHN who have either a local regional recurrence or distant metastases or both</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>○ As a single agent or in combination with a platinum based regimen for recurrent, second primary or metastatic SCCHN</li> </ul> <ul style="list-style-type: none"> <li>• The treatment of squamous cell carcinoma of the skin as a single agent for recurrent or distant metastases</li> </ul>
<p><b>Rybrevant (amivantamab-vmjw)</b></p> <p><b>Managed under medical benefit</b></p>	<p><b>Rybrevant (amivantamab-vmjw) may be considered medically necessary for when all the following criteria are met:</b></p> <ul style="list-style-type: none"> <li>• The individual is 18 years of age or older</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>• The individual has been diagnosed with locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 20 insertion mutations</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>• The individual meets one of the following: <ul style="list-style-type: none"> <li>○ Disease has progressed on or after platinum-based (eg, cisplatin, carboplatin, oxaliplatin) chemotherapy</li> </ul> </li> </ul>



Drug	Medical Necessity
	<ul style="list-style-type: none"> <li>○ Rybrevant (amivantamab-vmjw) will be first-line treatment used in combination with carboplatin and pemetrexed</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>• The maintenance dose is limited to 1,400 mg every 2 weeks if given as a single agent OR 2,100 mg every 3 weeks if given in combination with chemotherapy</li> </ul>
<p><b>Vectibix (panitumumab)</b></p> <p><b>Managed under medical benefit</b></p>	<p><b>Vectibix (panitumumab) may be considered medically necessary for:</b></p> <ul style="list-style-type: none"> <li>• The treatment of metastatic colorectal cancer (mCRC) when individual has not had prior Erbitux (cetuximab) therapy and when used: <ul style="list-style-type: none"> <li>○ As a single agent in first or later line of therapy for documented KRAS and NRAS wild-type mCRC</li> </ul> </li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>○ In combination with the FOLFIRI or FOLFOX regimen in first or later line of therapy for documented KRAS and NRAS wild-type mCRC</li> </ul>

**Investigational**

**Use of Erbitux (cetuximab), Rybrevant (amivantamab-vmjw), and Vectibix (panitumumab) to treat other types of solid tumors and hematological malignancies not listed above is considered investigational.**

Analysis	Medical Necessity
<p><b>KRAS and NRAS mutation analysis</b></p>	<p><b>KRAS and NRAS mutation analysis may be considered medically necessary for predicting treatment response.</b></p> <p><b>Note:</b> See the <a href="#">Erbitux (cetuximab)</a> and <a href="#">Vectibix (panitumumab)</a> sections above.</p>
<p><b>BRAF</b></p>	<p><b>BRAF mutation analysis may be considered medically necessary to predict nonresponse in the treatment of metastatic colorectal cancer.</b></p>



Length of Approval	
Approval	Criteria
<b>Initial authorization</b>	<p>Oral drugs listed in policy may be approved up to 3 months.</p> <p>Injectable drugs listed in policy may be approved up to 6 months.</p>
<b>Re-authorization criteria</b>	<p>Future re-authorization of oral and injectable drugs may be approved up to 12 months as long as the drug-specific coverage criteria are met and chart notes demonstrate that the individual continues to show a positive clinical response to therapy.</p>

Documentation Requirements
<p>The individual's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:</p> <ul style="list-style-type: none"> <li>Office visit notes that contain the diagnosis, relevant history, physical evaluation and medication history</li> </ul>

## Coding

Code	Description
<b>HCPCS</b>	
J9055	Injection, cetuximab (Erbix), 10 mg
J9061	Injection, amivantamab-vmjw, (Rybrevant) 2 mg
J9303	Injection, panitumumab (Vectibix), 10mg

**Note:** CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

## Related Information



## Benefit Application

### Pharmacy Benefit

Generic erlotinib, Gilotrif (afatinib), Iressa (gefitinib), Tagrisso (osimertinib), Tarceva (erlotinib), and Vizimpro (dacomitinib) are managed through the Pharmacy benefit.

### Medical Benefit

Erbix (cetuximab), Rybrevant (amivantamab-vmjw), and Vectibix (panitumumab) are managed through the Medical benefit.

## Evidence Review

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### Description

Cancer is characterized by the uncontrolled growth and spread of malignant cells. Nearly 1.4 million Americans will be diagnosed with cancer this year, and approximately 570,000 will die of the disease. The good news is survival rates for cancer are on the rise, increasing from 50% to 64% over the last 30 years.

Conventional cytotoxic cancer chemotherapy has been one of the major medical advances realized in the last few decades. Although directed toward certain biologic targets thought to be involved in cellular growth and proliferation, typically they have not discriminated well between rapidly dividing normal cells (eg, bone marrow, gastrointestinal tract) and tumor cells, frequently resulting in toxicities. In addition, tumor responses to traditional cytotoxic cancer chemotherapies can be unpredictable and brief.

"Targeted chemotherapies" (eg, monoclonal antibodies, small molecule tyrosine kinase inhibitors) are the newest therapeutic approach. These agents have been designed to interfere with Epidermal Growth Factor Receptor proteins, which are molecular targets that have a role in tumor growth and progression. These target proteins are typically preferentially expressed in tumor cells, thus these therapies have a higher specificity for these cells than for normal tissues. The promise of these agents is they will provide a broader therapeutic index with less toxicity. They may also be useful in combination with traditional cytotoxic chemotherapies,





immunotherapies or radiation to produce additive or synergistic activity without overlap in toxicity profiles.

The epidermal growth factor receptor (EGFR; ErbB-1; HER1 in humans) is the cell-surface receptor for members of the epidermal growth factor family (EGF-family) of extracellular protein ligands. The epidermal growth factor receptor is a member of the ErbB family of receptors, a subfamily of four closely related receptor tyrosine kinases: EGFR (ErbB-1), HER2/c-neu (ErbB-2), Her 3 (ErbB-3) and Her 4 (ErbB-4). EGFR plays a critical role in the modulation of growth factor signaling. The binding of a ligand such as epidermal growth factor to EGFR induces phosphorylation of several tyrosine residues near the C-terminal end of the EGFR protein and subsequent activation of several tyrosine kinase signal pathways such as the MAPK, Akt and JNK pathways. The induction of these signaling cascades enhances activities such as up regulation of RAS, RAF and mitogen-activated phosphorylation (MAP) which develop cellular growth and invasive capacity. EGFR activation also stimulates vascular endothelial growth factor (VEGF), which is the primary inducer of angiogenesis. As solid tumors cannot grow without the nutritional support provided by a blood supply, angiogenesis plays a key role in progression of these tumors. This feature makes the ErbB family of receptor proteins natural targets for development of novel antitumor compounds.

EGFR overexpression has been identified in a variety of solid tumors (eg, colorectal, lung, breast, kidney, liver). Furthermore, increasing VEGF levels have been correlated with poor prognosis in many of these same pathologies. As a result, EGFR, tyrosine kinase, and VEGF inhibitors have been developed and investigated for the treatment of these conditions. However, much remains to be learned regarding the rational integration of these therapies into cancer treatment regimens and methods to optimize the selection of individuals most likely to benefit.

## **KRAS/BRAF**

The RAS-RAF-MAP kinase pathway is activated in the EGFR cascade. RAS proteins are G-proteins that cycle between active (RAS-GTP) and inactive (RAS-GDP) forms, in response to stimulation from a cell surface receptor such as EGFR, and act as a binary switch between the cell surface EGFR and downstream signaling pathways. The GTPase KRas (KRAS) gene can harbor oncogenic mutations that result in a constitutively activated protein, independent of EGFR ligand binding, rendering antibodies to the upstream EGFR ineffective. KRAS mutations are found in approximately 30–50% of colorectal cancer tumors and are common in other tumor types.

Serine/threonine-protein kinase B-Raf (BRAF) encodes a protein kinase, and is involved in intracellular signaling and cell growth and is a principal downstream effector of KRAS. BRAF



mutations occur in less than 10–15% of colorectal cancers, and appear to be a marker of poor prognosis.

Recent studies have discovered that EGFR inhibition is not effective in treating tumors that have a mutation in the K-RAS gene. It is thought that the mutant gene is in an activated state and therefore does not require signal initiation from the EGF Receptor, which is located earlier in the signaling pathway.

However, there are still individuals with KRAS wild-type tumors that do not respond to these agents, suggesting that other factors, such as alterations in other EGFR effectors could drive resistance to anti-EGFR therapy, and therefore, BRAF mutations are now increasingly being investigated in metastatic colorectal cancer. KRAS and BRAF mutations are considered to be mutually exclusive.

The EGFR inhibiting agents currently available are as follows:

**Table 1. EGFR Inhibiting Agents**

Drug Name	Pharmacology	How Given	FDA-Approved Uses
<b>Small Molecules (acting inside the cell)</b>			
Afatinib (Gilotrif)	Kinase inhibitor	Oral (Rx)	*NSCLC
Dacomitinib (Vizimpro)	Kinase inhibitor	Oral (Rx)	NSCLC
Erlotinib (Tarceva)	Kinase inhibitor	Oral (Rx)	NSCLC, pancreatic cancer
Gefitinib (Iressa)	Tyrosine kinase inhibitor	Oral (Rx)	NSCLC
Osimertinib (Tagrisso)	Kinase inhibitor	Oral (Rx)	NSCLC
<b>Monoclonal Antibodies (acting at the cell membrane surface)</b>			
Amivantamab-vmjw (Rybrevant)	EGFR and MET antagonist	IV (Clinic)	NSCLC
Cetuximab (Erbix)	EGFR antagonist	IV (Clinic)	Metastatic *CRC, Head/Neck
Panitumumab (Vectibix)	EGFR antagonist	IV (Clinic)	Metastatic CRC

\*NSCLC – Non-small cell lung cancer

\*CRC – Colorectal cancer



Erlotinib (Tarceva) is approved for the treatment of individuals with metastatic NSCLC and metastatic pancreatic cancer. Although its mechanism of action is not fully characterized, it is believed to selectively and reversibly inhibit the intracellular phosphorylation of EGFR tyrosine kinase. EGFR is expressed in NSCLC, as well as numerous other solid tumors.

Three additional growth factor inhibitors differ mechanistically in that they are monoclonal antibodies to the receptors:

- Erbitux (cetuximab) is a recombinant chimeric monoclonal antibody that binds and inhibits human epidermal growth factor receptor (EGFR, HER1, c-ErbB-1) on normal and tumor cells. This binding prevents the phosphorylation and activation of kinases, resulting in the inhibition of cell growth, induction of apoptosis, and decrease in VEGF production.
- Rybrevant (amivantamab-vmjw) is a bispecific antibody that binds to the extracellular domains of EGFR and MET. In in vitro and in vivo studies amivantamab-vmjw was able to disrupt EGFR and MET signaling functions through blocking ligand binding and, in exon 20 insertion mutation models, degradation of EGFR and MET. The presence of EGFR and MET on the surface of tumor cells also allows for targeting of these cells for destruction by immune effector cells, such as natural killer cells and macrophages, through antibody-dependent cellular cytotoxicity (ADCC) and trogocytosis mechanisms, respectively.
- Vectibix (panitumumab) is a recombinant fully human monoclonal antibody that binds and inhibits human epidermal growth factor receptor (EGFR). It is produced in genetically engineered Chinese Hamster ovary cells.

## National Comprehensive Cancer Network Compendium

The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium is based directly on the NCCN Clinical Practice Guidelines in Oncology. The compendium lists specific panel recommendations for off-label uses of drugs, and each recommendation is supported by a level of evidence category.

The NCCN Categories of Evidence and Consensus used in the recommendations are:

- **Category 1:** The recommendation is based on high level evidence (eg, randomized controlled trials) and there is uniform NCCN consensus.
- **Category 2A:** The recommendation is based on lower level evidence and there is uniform NCCN consensus.



- **Category 2B:** The recommendation is based on lower level evidence and there is nonuniform NCCN consensus (but no major disagreement).
- **Category 3:** The recommendation is based on any level of evidence but reflects major disagreement.

## Lung Cancer

Non-small cell lung cancer (NSCLC) is potentially curable if diagnosed early (Stage I or II). Unfortunately, approximately 75% of cases are not identified until the individual has locally advanced or metastatic disease (i.e., Stage III or IV). Overall, five year survival is only about 15%.

Two chemotherapy agents (doublet) are recommended by NCCN for first-line therapy of individuals with advanced NSCLC and good performance status (i.e., ECOG performance status 0-2). Individuals with poor performance status (i.e., 3 or 4) generally do not benefit from chemotherapy. Specifically, platinum-based regimens are recommended. Newer agents in combination with platinum agents have generated a plateau in overall response rate (ORR) of  $\geq 25\text{-}35\%$ , time to progression (TTP) of four to six months, median survival of eight to 10 months, and one-year survival of 30-40%. None of these newer combinations has been shown to be clearly superior.

As understanding of the pathophysiology of NSCLC has improved, and because most individuals with advanced disease continue to progress following first-line chemotherapy and ultimately die within a year, newer therapies have been developed that have demonstrated value in prolonging survival in this setting. Single-agent docetaxel is considered the standard for comparison for second-line therapy of advanced or recurrent metastatic NSCLC. A large randomized head-to-head study showed pemetrexed 500 mg/m<sup>2</sup> provided similar response and survival rates with less severe adverse events and fewer hospitalizations compared to docetaxel 75 mg/m<sup>2</sup>.

## Iressa (gefitinib)

The safety of Iressa (gefitinib) is based on the data from 2462 individuals with NSCLC who received Iressa 250 mg daily monotherapy in three randomized clinical studies (Study 2, Study 3 and Study 4). Individuals with a history of interstitial lung disease, drug-induced interstitial disease, radiation pneumonitis that required steroid treatment or any evidence of clinically active interstitial lung disease were excluded from these studies.



Study 2 was a randomized, multicenter, open-label trial in which 1217 individuals were randomized to receive first-line treatment for metastatic NSCLC; 607 individuals received Iressa 250 mg daily and 589 individuals received carboplatin/paclitaxel. The median duration of treatment with Iressa was 5.9 months. The study population characteristics were: median age 57 years, age less than 65 years (73%), female (79%), Asian (100%), NSCLC adenocarcinoma histology (100%), never smoker (94%), light ex-smoker (6%), ECOG PS 0 or 1 (90%).

Study 3 was a randomized, multicenter, double-blind, placebo-controlled trial in which 1692 individuals were randomized to receive second- or third-line treatment for metastatic NSCLC; of which 1126 individuals received Iressa 250 mg daily and 562 individuals received placebo. The median duration of treatment with Iressa was 2.9 months. The study population characteristics were: median age 62 years, age less than 65 years (60%), female (33%), Caucasian (75%), Asian (21%), NSCLC adenocarcinoma histology (48%), never smoker (22%), ECOG PS 0 or 1 (65%), PS 2 (29%), PS 3 (5%) and two or more prior therapies (51%).

Study 4 was a randomized, multicenter, open-label trial in which 1466 individuals were randomized to receive second-line treatment for metastatic NSCLC; 729 individuals received Iressa 250 mg daily and 715 individuals received docetaxel. The median duration of treatment with Iressa was 2.4 months. The study population characteristics were: median age 61 years, age less than 65 years (61%), female (36%), Caucasian (79%), Asian (21%), NSCLC adenocarcinoma histology (54%), never smoker (20%), ECOG PS 0 or 1 (88%) and two or more prior therapies (16%).

The pooled safety database from the three randomized trials was used to evaluate for serious and uncommon adverse drug reactions. Common adverse reactions were evaluated in Study 3. The most frequent adverse reactions in Study 3 (incidence of >20% and greater than placebo) reported in Iressa-treated individuals were skin reactions (47%) and diarrhea (29%). The most frequent fatal adverse reactions in Iressa-treated individuals were respiratory failure (0.9%), pneumonia (0.8%), and pulmonary embolism (0.5%).

Approximately 5% of Iressa-treated individuals and 2.3% of placebo-treated individuals discontinued treatment due to an adverse event. The most frequent adverse reactions that led to discontinuation in individuals treated with Iressa were nausea (0.5%), vomiting (0.5%) and diarrhea (0.4%).

## **Tarceva (erlotinib)**

Tarceva (erlotinib) has proven survival benefit as a second- or third-line therapy for the treatment of individuals with chemotherapy refractory (typically a platinum-based regimen)



advanced or recurrent metastatic NSCLC compared to basic supportive care. It has a unique and milder side effect profile compared with traditional cytotoxics (e.g., docetaxel) recommended for use in this setting. It also offers the convenience and potential advantages of oral versus invasive administration as a second-line therapy.

A retrospective study of individuals treated with first-line chemotherapy with and without erlotinib found that the median overall survival for all individuals with mutations was significantly better (>20 months,  $P < .001$ ) than overall survival for individuals without mutations (10 months).

## **Erbix (cetuximab)**

Use of Erbitux (cetuximab), a monoclonal antibody targeting the epidermal growth factor receptor (EGFR), has the potential to increase survival in individuals with advanced NSCLC. In a 1125 individual multinational, multicenter, open-label, phase 3 trial, chemotherapy-naïve individuals with advanced EGFR-expressing histologically or cytologically proven Stage III B or Stage IV NSCLC were randomly assigned in a 1:1 ratio to chemotherapy plus cetuximab ( $n=557$ ) or just chemotherapy ( $n=568$ ). Individuals given chemotherapy plus cetuximab survived longer than those in the chemotherapy-alone group.

## **Gilotrif (afatinib)**

One single arm phase II study and two phase III open label studies compared Gilotrif (afatinib) with standard chemotherapies as a first line treatment for individuals with advanced or metastatic NSCLC. All individuals were newly diagnosed, treatment naïve, stage III B or IV with activating EGFR mutations. The results showed modest efficacy of afatinib compared with standard chemotherapy. There are no comparative efficacy data for afatinib vs. previous TKIs in common mutations (exon 19 deletion/L858R), or in preventing T790M resistance.

In the LUX-Lung 3 study, afatinib significantly prolonged PFS (11.1 months) vs. cisplatin/pemetrexed (6.9 month) (HR: 0.58 [95% CI: 0.43, 0.78];  $P < 0.001$ ), but not overall survival. Median PFS was longer (13.6 months, HR: 0.47 [95% CI: 0.34, 0.65];  $P < 0.0001$ ) with common EGFR mutations (Del19 and L858R). Afatinib significantly delayed the time to deterioration for cough (HR: 0.60 [95% CI 0.41 to 0.87];  $P = 0.007$ ) and dyspnea (HR: 0.68 [95% CI 0.50 to 0.93];  $P = 0.015$ ), but not pain (HR: 0.83 [95% CI 0.62 to 1.10];  $P = 0.19$ ). However, the study included no maintenance therapy in chemotherapy group, and there was potential investigator bias due to the awareness of new NCCN guidelines and high cross over rates.



The LUX-Lung 6 study compared efficacy and safety of afatinib to gemcitabine/cisplatin as first-line treatment in an Asian population with EGFR positive mutations. The design and results were similar to LUX-Lung 3. Afatinib prolonged PFS as compared to gemcitabine/cisplatin (11 months vs. 5.6 months, HR 0.28 [95% CI 0.20, 0.39]; P=0.0001). LUX-Lung 2 is a single arm, phase II study of afatinib as first and second line therapy in individuals from Taiwan and USA. Two doses of afatinib (50 mg and 40 mg) were tested in this study. The results were similar compared to LUX-Lung 3 and LUX-Lung 6: ORR was 61%, median PFS was 10.1 month and overall survival was 24.8 months for all individuals.

The most common adverse events (AE) with afatinib were diarrhea (95.2%), rash (90%), dryness, and irritation of the skin, mucosa and nails. Although the discontinuation rate was lower in afatinib (8%) versus chemotherapy (12%), almost half of afatinib individuals required dose reduction to less than 40 mg per day and 14% discontinued therapy due to AE. Diarrhea and rash occurred in more than 90% of individuals. Serious AE included several cases of interstitial lung disease and 4 deaths potentially due to treatment related fatal toxicity. This suggests that afatinib may not be well tolerated, and more data are needed to ensure its safe use in a wider population. Afatinib improved PFS and quality of life as a first-line treatment for individuals with metastatic NSCLC whose tumors have activating EGFR mutations. It is not metabolized by CYP450 enzymes as are other EGFR TKIs.

## Tagrisso (osimertinib)

The evidence base for the approval of osimertinib consists of 2 single-arm, open-label trials (Study 1, Study 2). The 2 studies were pooled for efficacy and adverse event outcomes because there were no substantial differences in the individual characteristics between studies. A total of 411 individuals with metastatic, EGFR T790M mutation-positive NSCLC who had received prior EGFR TKI therapy were recruited and treated with osimertinib 80 mg until progression or unacceptable toxicity. The primary end points were ORR by RECIST criteria as assessed by central independent review and adverse events. Secondary end points included dose-limiting toxicity, duration of response, and PFS.

In Study 1, no individuals achieved a complete response. Partial response was achieved in 115 individuals, for an ORR of 57% (95% CI, 50% to 64%). Study 2 had 2 complete responses and 126 partial responses, with an ORR of 59% (95% CI, 54% to 64%). Among responders, most individuals (96%) had ongoing responses, ranging from 1.1 to 5.6 months, with a median duration of follow-up of 4.2 months in study 1 and 4 months in study 2. Pooled overall ORR was 59% (95% CI, 54% to 64%).



## Rybrevent (amivantamab-vmjw)

The efficacy of Rybrevent was evaluated in individuals with locally advanced or metastatic NSCLC with EGFR exon 20 insertion mutations in a multicenter, open-label, multi-cohort clinical trial (CHRYSALIS, NCT02609776). The study included individuals with locally advanced or metastatic NSCLC with EGFR exon 20 insertion mutations whose disease had progressed on or after platinum-based chemotherapy. Individuals with untreated brain metastases and individuals with a history of interstitial lung disease requiring treatment with prolonged steroids or other immunosuppressive agents within the last 2 years were not eligible for the study.

In the efficacy population, EGFR exon 20 insertion mutation status was determined by prospective local testing using tissue (94%) and/or plasma (6%) samples. Of the 81 individuals with EGFR exon 20 insertion mutations, plasma samples from 96% of individuals were tested retrospectively using Guardant360 CDx. While 76% of individuals had an EGFR exon 20 insertion mutation identified in plasma specimen, 20% did not have an EGFR exon 20 insertion mutation identified in plasma specimen, and 3.7% did not have plasma samples for testing. The overall response rate was 40% with 3.7% of participants having a complete response and 36% of participants with a partial response.

## Colorectal Cancer

Cetuximab has been studied as both a single agent and in combination with irinotecan in the treatment of metastatic colorectal cancer.<sup>28</sup>

## Pancreatic Cancer

In pancreatic cancer symptoms are typically minor until the disease has significantly progressed, and following diagnosis the tumor is often resistant to standard anticancer therapies. These factors contribute to a high mortality rate, with only 20% of individuals surviving to one year. In individuals with advanced pancreatic cancer, one-year survival drops to approximately 10%. The current standard of therapy in unresectable, advanced, and metastatic disease is gemcitabine.

A randomized, double-blind, placebo-controlled clinical trial added erlotinib 100 mg/day to gemcitabine in individuals with inoperable advanced pancreatic cancer. The results showed modest survival benefit compared to those receiving gemcitabine alone. There was a significant





difference in overall survival [ $p=0.025$ ] that favored the erlotinib plus gemcitabine group with a hazard ratio of 0.81 [95% CI 0.67 - 0.97]. The corresponding one-year survival rates were 24% versus 17%. PFS was also significantly improved in the gemcitabine plus erlotinib treatment group with a hazard ratio of 0.76,  $p=0.003$ . The RR [CR/PR/SD] were 58% [CR/PR=9%] and 49% [CR/PR=8%] for the erlotinib and placebo groups, respectively. No unexpected adverse events or safety signals were reported.

## Hepatocellular Carcinoma

Hepatocellular carcinoma is the third leading cause of cancer deaths worldwide. Surgical resection and liver transplantation are the only cures for hepatocellular carcinoma but benefit only 15% of individuals. Most cases are fatal within one year of diagnosis. Soratenib is the only pharmacotherapy option available for advanced, inoperable hepatocellular carcinoma (HCC).

One Phase II study (N=137 individuals) looked at the safety and efficacy of four week cycles of 400 mg twice daily soratenib given to individuals with inoperable HCC, no prior systemic treatment and Child-Pugh A or B scores. After independent assessment, three individuals (2.2%) had a partial response, eight individuals (5.8%) had minor response and 46 individuals (33.6%) had stable disease for at least 16 weeks. The median time to progression was 4.2 months and median overall survival was 9.2 months. Adverse events included fatigue, diarrhea, and hand-foot skin reaction.

One Phase III study (N=602) looked at the efficacy and safety of 400 mg soratenib twice daily compared to placebo in individuals with advanced HCC, no prior systemic treatment, ECOG 0-2 and Child-Pugh A. Primary endpoints were median overall survival (OS) and time to symptomatic progression (TTSP). The hazard ratio for OS was 0.69 for sorafenib versus placebo which represented 44% improvement in OS. This was the basis for early stopping criteria. The median overall survival advantage was 10.7 months for sorafenib versus 7.9 months for placebo. The hazard ratio for TTSP was 0.58 and median TTP was 5.5 months for sorafenib vs 2.8 months for placebo. Adverse events incidences were similar between the two groups; however, more serious adverse events of diarrhea and hand-foot skin reactions were seen in the sorafenib group.



## 2008 Update

### K-RAS Mutations and Their Impact on the Clinical Effectiveness EGFR Inhibitors

Many retrospective observational studies have been performed to evaluate the contribution of mutations downstream of the epithelial growth factor receptor (EGFR) on the efficacy of the anti-EGFR tyrosine kinase inhibitor oncology therapies such as cetuximab, panitumumab, and gefitinib. Studies differ in design, individual demographics, and therapeutic regimens. The majority of studies evaluating the association of K-RAS mutation with treatment resistance conclude that wild type status is associated with a more favorable response to treatment. Higher efficacy is often seen among tumors with wild-type K-RAS, including a higher percent and degree of response, overall survival, and time-to-progression. However, no single outcome is consistently statistically significant among all studies. Currently available evidence suggests that K-RAS mutation is associated with poor response to TKI therapy, with the most evidence being for cetuximab. At this time, K-RAS mutation status neither predicts resistance to therapy, nor does the presence of wild-type allele predict good efficacy.

A statistically significant difference in overall response was seen in 10 of 13 studies in which response was an outcome. Response rates among K-RAS mutants ranged from 0% to 33%. Only 5 of 13 studies that measured response reported any response to TKI treatment, ranging from 9.5% to 33%. No studies assessing response to panitumumab reported any response to therapy in the K-RAS mutant group. In general, the presence of K-RAS mutation is associated with decreased response to TKI treatment. However, studies presenting response rates of approximately 10-30% suggest that the existence of K-RAS mutation is not the sole determinant of treatment response. In addition, the percent of K-RAS wild-type subjects with partial or complete response is still relatively low, ranging from 26-68%. This suggests that while K-RAS likely contributes the TKI resistance, other factors are involved.

Seven of 15 studies assessed overall survival as an outcome. Three of these found no statistically significant difference, and one found a difference in overall survival only among individuals taking combination therapy of cetuximab with irinotecan, while no difference in overall survival was seen in the same individuals taking cetuximab monotherapy. The remaining three found statistically significant differences in overall survival between K-RAS mutants and K-RAS wild-type. All three assessed response to cetuximab. Comparison of the overall survival of mutants versus wild-type found an overall median response rate of 6.9 months and 16.3 months, respectively ( $p < 0.001$ ), 27.3 weeks versus 44.7 weeks, respectively ( $p = 0.003$ ), and 10.1 months versus 14.3 months, respectively ( $p = 0.026$ ). Overall, half of the studies that measured overall survival as an outcome reported a difference between K-RAS mutants and K-RAS wild type. The



largest study performed with overall survival as an outcome, consisting of 427 individuals, found that there was no difference in overall survival between K-RAS mutants and K-RAS wild type after treatment with panitumumab.

Eleven of 15 studies assessed progression-free-survival (PFS) or time-to-progression (TTP). Three of these directly compared TTP or PFS between K-RAS mutants and K-RAS wild type after treatment with cetuximab found no statistically significant difference. However, six studies directly comparing them confirmed that there was a difference. After treatment with cetuximab, TTP for K-RAS mutants and K-RAS wild type were 10.1 weeks [95% CI, 8 to 16 weeks] and 31.4 weeks [95% CI, 19.4 to 36 weeks], respectively. PFS was 6.9 months versus 16.3 months for mutants and wild-type, respectively ( $p=0.016$ ). One study found a statistically significant difference in progression-free survival only with cetuximab combined with irinotecan (12 weeks versus 34 weeks,  $p=0.016$ ), but not for cetuximab monotherapy. When randomized to best supportive care or best supportive care and panitumumab, subjects with K-RAS mutations showed no difference in PFS between the two treatment arms. In K-RAS wild-type individuals, a statistically significant difference in PFS was seen (HR 0.45, 95%CI -.34-0.59). One study with individuals taking either cetuximab or panitumumab reported difference in PFS of 8.6 weeks in K-RAS mutants versus 32 weeks in K-RAS wild type ( $p<0.001$ ). Two abstracts presented at the American Society of Clinical Oncology (ASCO) 2008 Annual Meeting evaluated the benefit of cetuximab as adjunct therapy to the standard regimen for metastatic colorectal cancer, FOLFIRI. Both studies found that the addition of cetuximab to standard therapy only resulted in increased median PFS in K-RAS wild-type individuals. K-RAS mutants showed no improvement in PFS. Overall, the evidence shows that K-RAS mutation is associated with shorter TTP and PFS after treatment with TKI than K-RAS wild type. However, K-RAS mutation has been independently associated with disease progression and this may contribute to differences in disease progression regardless of therapy.

Karapetis et al. published a study that used tissue samples from the CO.17 trial of cetuximab versus supportive care in treating refractory advanced stage metastatic colorectal cancer individuals. Five hundred seventy-two individuals were enrolled in the original clinical trial, of which tissue samples were examined for 394 individuals (69%). The remainder was unavailable for logistic reasons, or due to lack of consent. The authors observed a five-month improvement in median overall survival (9.5 months in the cetuximab group versus 4.8 months with supportive care) for individuals with wild type K-RAS. There was no difference in survival between cetuximab and supportive care groups for individuals with K-RAS mutations.



## 2009 Update

### The National Comprehensive Cancer Network Drug Compendium

The Company recognizes indications and uses of drugs listed in the NCCN Drugs and Biologics Compendium with Categories of Evidence and consensus of 1 and 2A as proven and Categories of Evidence and Consensus of 2B and 3 as unproven. However, Category 2B uses may be considered for coverage if they are substantiated by provider submission of significant peer-reviewed phase 2 or phase 3 studies demonstrating treatment effectiveness.

Schneider et al. studied the effect of various polymorphisms involving the EGFR signaling pathway in 311 individuals receiving erlotinib in NSCLC. None of 17 individuals with a KRAS mutation had a tumor response, but the impact of KRAS mutation status on survival outcomes was of borderline statistical significance. Similarly, Miller et al. studied a series of 101 individuals with bronchioalveolar carcinoma, of which no individual (zero of 18; 95% CI, 0% to 19%) whose tumor harbored a KRAS mutation responded to erlotinib.

## 2010 Update

This policy is updated in agreement with March 2010 NCCN Drugs and Biologics Compendium recommendations of 1 and 2A.

## 2011 Update – KRAS/BRAF

### Technology Assessments, Guidelines and Position Statements

The National Comprehensive Cancer Network (NCCN) guidelines (1.2011) on the treatment of colon cancer recommend that tumor KRAS gene status testing be performed for all individuals with metastatic colon cancer. This testing would be done on archived specimens of primary tumor or a metastasis, at the time of diagnosis of metastatic disease. The guidelines indicate that cetuximab and panitumumab are only indicated for individuals with tumors that express the wild-type KRAS gene (category 2A recommendation). The guidelines state that there is the option of BRAF genotyping of tumor tissue at the diagnosis of KRAS wild-type stage IV disease, but that data regarding BRAF as a predictor of response (or lack of) to anti-EGFR therapy remain inconclusive.



## Summary

Clinical trial data show that individuals with KRAS-mutated metastatic colorectal cancer do not benefit from cetuximab or panitumumab, either as monotherapy or in combination with other treatment regimens. These data support the use of KRAS mutation analysis of tumor DNA before considering use of cetuximab or panitumumab in a treatment regimen. Identifying individuals whose tumors express mutated KRAS will avoid exposing individuals to ineffective drugs and unnecessary drug toxicities, and expedite the use of alternative therapies. Thus, KRAS mutation analysis may be considered medically necessary to predict nonresponse to anti-EGFR monoclonal antibodies cetuximab and panitumumab in the treatment of metastatic colorectal cancer.

The data for individuals with metastatic colorectal cancer and a BRAF mutation have shown consistently that a BRAF mutation is a poor prognostic marker, as it is associated with shorter PFS and OS regardless of treatment. The data for a BRAF mutation predicting response to anti-EGFR therapy are limited by small numbers of individuals and conflicting results among studies. However, recent data (currently unpublished) from the CRYSTAL trial suggest that individuals with KRAS wild-type/BRAF mutant tumors may respond to anti-EGFR therapy. Therefore, it may be considered an option in the diagnosis of KRAS wild-type Stage IV disease. Non-concurrent subgroup analyses of BRAF mutations in individuals previously randomized in the large trials in which KRAS mutations predicted non responsiveness to anti-EGFR therapy will be helpful to confirm the current data available for BRAF mutations.

## 2013 Update

This policy is updated in agreement with November 2013 NCCN Drugs and Biologics Compendium recommendations of 1 and 2A. Criteria for afatinib, a new oral EGFR inhibitor, were added. A literature search from January 1, 2013 did not identify further required changes.

## 2014 Update

This policy is updated with a literature search from 7/1/13 to 10/31/14. No further required changes.



## 2015 Update

This policy is updated with a literature search from 7/1/14 to 10/31/15. No further required changes. Revision is planned for first quarter 2016. Reviewed by the Pharmacy and Therapeutics committee November 19, 2015.

## 2016 Update

This policy was updated to include a new kinase inhibitor, Tagrisso (osimertinib) used for the treatment of NSCLC. A revised indication for Tarceva (erlotinib) used for the treatment of NSCLC was added.

## 2020 Update

Reviewed prescribing information for all drugs. No new evidence was identified that required changes to coverage criteria.

## 2021 Update

Reviewed prescribing information for all drugs in policy. No new evidence was identified that required changes to coverage criteria. Added a new drug to policy called Rybrevant (amivantamab-vmjw) for the treatment of locally advanced or metastatic NSCLC with EGFR exon 20 insertion mutations.

## 2022 Update

Reviewed prescribing information for all drugs in policy. No new evidence was identified that required changes to coverage criteria.

## 2023 Update

Reviewed prescribing information for all drugs in policy. No new evidence was identified that required changes to coverage criteria.



## 2024 Update

Reviewed prescribing information for all drugs in policy. Added coverage criteria for generic gefitinib. Updated coverage criteria for Iressa (gefitinib) to require trial and failure with generic gefitinib. Updated coverage criteria for Tarceva (erlotinib) to require trial and failure with generic erlotinib. Updated coverage criteria for Tagrisso (osimertinib) to include treatment of certain adult individuals with locally advanced or metastatic non-small cell lung cancer. Updated Rybrevant (amivantamab-vmjw) coverage criteria to include first-line treatment of certain individuals with non-small cell lung cancer in combination with chemotherapy. Updated Rybrevant (amivantamab-vmjw) coverage criteria to include a quantity limit.

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60. Vectibix (panitumumab) [package insert]. Thousand Oaks, CA: Amgen Inc.; Revised August 2021.
61. Vizimpro (dacomitinib) [package insert]. New York, NY: Pfizer Inc.; Revised December 2020.

## History

Date	Comments
03/08/05	Add to Prescription Drug Section - New Policy. Hold for notification, publish June 1, 2005
10/01/05	Replace Policy - Medco issue resolved, approved text being added back into Policy Statement and Policy Guidelines. No review needed by MPC.
02/14/06	Replace Policy - Policy reviewed and revised per Pharmacy and Therapeutics Committee on 1/31/06. Title changed from Epidermal Growth Factor Receptor Inhibitors
06/16/06	Update Scope and Disclaimer - No other changes.
06/21/06	Update codes only. - No other changes.
08/08/06	Replace Policy - Policy reviewed by Pharmacy and Therapeutics Committee on 7/25/06; no changes in policy statement; policy guidelines updated.



Date	Comments
03/13/07	Replace Policy - Policy updated with literature review; references updated. Indications for Sprycel, Nexavar, Sutent and Vectibix added to policy statement; indications for Avastin in the treatment of ovarian cancer added as an investigational policy statement, and medically necessary in the treatment of diabetic retinopathy. Policy Guidelines and Rationale updated.
04/10/07	Replace Policy - Policy reviewed by P&T March 27, 2007. Policy statement updated to clarify the indications and criteria for medically necessary treatment with Gleevec and Sprycel. Policy Guidelines updated.
12/11/07	Replace Policy - Policy updated with literature review; policy statement updated to include bullet point "treatment of patients with advanced hepatocellular carcinoma (HCC)" as medically necessary under Sorafenib (Nexavar). Rationale and references updated to support change in statement.
08/12/08	Replace Policy - Policy updated with literature search. Policy statement revised to indicate that Erbitux may be considered medically necessary for head and neck cancer. Comment on testing for K-RAS mutations added to Policy Guidelines. Rationale section updated, references added. Reviewed by P&T July 24, 2008
11/11/08	Update Description Section - No other changes.
07/14/09	Replace Policy - Policy updated with literature search. Policy statements extensively revised. References added.
09/15/09	Minor updates, code updates - 3rd bullet added under Tarceva's policy statement "documentation of susceptibility to EGFR mutation or gene amplification". No other changes. Code S3713 added.
10/13/09	Replace Policy - Policy updated with literature search. Two bullets added under the Nexavar medically necessary statement regarding gastrointestinal stromal tumors and soft-tissue sarcoma. References added.
01/12/10	Replace Policy - Policy updated with literature search; no change to the policy statement. Policy guidelines updated.
05/11/10	Replace Policy - Policy updated with literature search. Policy statement updated to include medical necessity statement for Erbitux. Reference added. Reviewed by OAP on February 18, 2010. Reviewed by P&T committee in March 2010.
9/14/10	Replace Policy - Policy statement for Erbitux updated with removal of IIIB pleural effusion/IV. Policy guidelines for Erbitux updated with removal of guidelines under NSCLC in accordance with NCCN guidelines. Reviewed by OAP on 8/19/10.
03/08/11	Replace Policy - Policy updated with literature search. BRAF, previously not addressed, may now be considered medically necessary in colon cancer. Reviewed by OAP 02/17/11.
05/10/11	Replace Policy - Policy updated with the abstraction of soratenib (Nexavar) and sinitinib (Sutent) which are now addressed in 5.01.534; reference to these drugs and



Date	Comments
	their ability to treat renal cell and thyroid cancers have been removed, along with associated references.
06/26/12	Replace policy. Literature review; no change in policy statements.
06/29/12	Coding update: CPT codes, 81275, 81403 and 88363 added to the policy.
12/19/12	Update Related Policy to add 5.01.01 and 9.03.504.
12/09/13	Replace policy. Policy updated in agreement with November 2013 NCCN Drugs and Biologics Compendium recommendations of 1 and 2A. Criteria for afatinib, a new oral EGFR inhibitor, were added. References 50 – 55 added. CPT codes 81275 and 88363 removed; they are not specific to this policy. Deleted code S3713 removed.
12/17/14	Annual review. Policy updated with literature review; no change in policy statements.
12/08/15	Annual Review. Policy updated with literature review; no change in policy statements. Reviewed by P & T November 2015.
04/01/16	Interim update, approved March 8, 2016. Addition of a new kinase inhibitor, osimertinib and its criteria to the policy.
05/01/16	Annual Review, approved April 12, 2016. Addition of recently revised indication for EGFR inhibitor, gefitinib and its criteria to the policy.
10/01/16	Interim Update, approved September 13, 2016. Inclusion of a new indication for Gilotrif. Potential update of criteria for Erbitux and Vectibix.
12/01/16	Minor update, approved November 8, 2016. A notation was added that this policy applies only to those 18 and older because data does not support efficacy and safety in those under 18.
06/01/17	Annual review, approved May 23, 2017. A statement outlining the length of therapy for initial approval has been added to the policy.
02/01/18	Interim Review, approved January 30, 2018. Inclusion of a new indication for Gilotrif.
07/01/18	Annual Review, approved June 12, 2018. Tagrisso and Gilotrif criteria were updated with new literature. Erbitux and Vectibix criteria were re-written for clarity and use of Erbitux for NSCLC was removed due to a large trial (S0819) of previously untreated advanced NSCLC patients randomized to paclitaxel plus carboplatin vs. paclitaxel plus carboplatin plus bevacizumab, with or without cetuximab failed to show overall or disease free survival advantage in the cetuximab arms. Removed HCPCS codes J8565 and J8999.
11/01/18	Interim Review, approved October 9, 2018. Added dacomitinib. Updated indications for all drugs based on labels. Remove code 81403, added code J9999.
04/01/19	Interim Review, approved March 19, 2019. Updated criteria for Tagrisso and Tarceva.
07/01/19	Annual Review, approved June 20, 2019. Update criteria for Erbitux and Vectibix. Added generic erlotinib to policy with identical criteria as Tarceva. Removed HCPCS code J9999.



Date	Comments
11/01/20	Annual Review, approved October 22, 2020. No changes to policy statements.
03/01/21	Interim Review, approved February 9, 2021. Added a new indication to Tagrisso (osimertinib) for adjuvant therapy after tumor resection in patients with NSCLC.
08/01/21	Annual Review, approved July 13, 2021. Added criteria for Rybrevant (amivantamab-vmjw) for the treatment of locally advanced or metastatic NSCLC with EGFR 20 insertion mutations. Added HCPCS code J3590.
10/01/21	Coding update, Added HCPCS code C9083.
01/01/22	Interim Review, approved December 21, 2021. Added HCPCS code J9061 and removed HCPCS code J3590. Added a new indication to Erbitux (cetuximab) for use in combination with Braftovi (encorafenib) for mCRC with a BRAF V600E mutation when used after prior therapy.
02/01/22	Interim Review, approved January 11, 2022. Added criteria for Exkivity (mobocertinib) for the treatment of adult patients with locally advanced or metastatic NSCLC with EGFR exon 20 insertion mutations, whose disease has progressed on or after platinum-based chemotherapy.
01/01/23	Annual Review, approved December 23, 2022. No changes to policy statements. Changed the wording from "patient" to "individual" throughout the policy for standardization. Removed termed HCPC code C9083 and new code details for HCPC code J9061.
10/01/23	Annual Review, approved September 11, 2023. No changes to the policy statements.
12/01/23	Interim Review, approved November 20, 2023. Removed criteria for Exkivity (mobocertinib) as it has been withdrawn from the market.
04/01/24	Annual Review, approved March 12, 2024. Added coverage criteria for generic gefitinib. Updated coverage criteria for Iressa (gefitinib) to require trial and failure with generic gefitinib. Updated coverage criteria for Tarceva (erlotinib) to require trial and failure with generic erlotinib. Updated coverage criteria for Tagrisso (osimertinib) to include treatment of certain adult individuals with locally advanced or metastatic non-small cell lung cancer.
06/01/24	Interim Review, approved May 14, 2024. Updated Rybrevant (amivantamab-vmjw) coverage criteria to include first-line treatment of certain individuals with non-small cell lung cancer in combination with chemotherapy. Updated Rybrevant (amivantamab-vmjw) coverage criteria to include a quantity limit.

**Disclaimer:** This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply.



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**Scope:** Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.





### Discrimination is Against the Law

LifeWise Health Plan of Washington (LifeWise) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). LifeWise provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that LifeWise has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-6396, Fax: 425-918-5592, TTY: 711, Email [AppealsDepartmentInquiries@LifeWiseHealth.com](mailto:AppealsDepartmentInquiries@LifeWiseHealth.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>.

### Language Assistance

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-817-3056 (TTY: 711).

**注意:** 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-817-3056 (TTY: 711)。

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-817-3056 (TTY: 711).

**주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-817-3056 (TTY: 711) 번으로 전화해 주십시오.

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-817-3056 (телетайп: 711).

**PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-817-3056 (TTY: 711).

**УВАГА!** Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 800-817-3056 (телетайп: 711).

**ប្រយ័ត្ន:** បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតលុយ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 800-817-3056 (TTY: 711)។

**注意事項:** 日本語を話される場合、無料の言語支援をご利用いただけます。800-817-3056 (TTY:711) まで、お電話にてご連絡ください。

**ማስታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 800-817-3056 (መስማት ለተሳናቸው፡ 711)።

**XIYYEEFFANNAA:** Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-817-3056 (TTY: 711).

**ملحوظة:** إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-817-3056 (رقم هاتف الصم والبكم: 711).

**ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-817-3056 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-817-3056 (TTY: 711).

**ໂປດອຸບ:** ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າສ່ຽງຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-817-3056 (TTY: 711).

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sévis èd pou lang ki disponib gratis pou ou. Rele 800-817-3056 (TTY: 711).

**ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-817-3056 (ATS : 711).

**UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-817-3056 (TTY: 711).

**ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-817-3056 (TTY: 711).

**ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-817-3056 (TTY: 711).

**توجہ:** اگر بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-817-3056 (TTY: 711) تماس بگیرید.