Prostate Cancer Targeted Therapies

Number: 5.01.544*
Effective Date: May 1, 2017
Revision Dates: 05/01/17; 01/01/17; 10/25/16; 12/08/15; 10/13/15; 12/08/14; 12/04/13; 07/08/13; 04/09/13
Replaces: N/A

*This policy is managed through the Pharmacy benefit.

**Policy**

**Note:** Initial approval period for agents listed below will be 3 months. Continued approval beyond the first 3 months will require documentation showing objective response to therapy.

Abiraterone (Zytiga®) may be considered medically necessary for treatment of patients with castrate-resistant prostate cancer when used in combination with prednisone.

Enzalutamide (Xtandi®) may be considered medically necessary when used:
- For the treatment of patients with castrate-resistant prostate cancer.
- In combination with androgen deprivation therapy (ADT):
  - As part of neoadjuvant/concomitant/adjuvant ADT to enhance effectiveness of radiation therapy.
  - In androgen deprivation therapy-naïve patients for a minimum of 7 days in patients with overt metastases who are at risk of developing symptoms associated with androgen flare.
  - Following inadequate testosterone suppression with ADT alone.

**Related Policies**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.01.517</td>
<td>Use of Vascular Endothelial Growth Factor Receptor (VEGF) Inhibitors and Other Angiogenesis Inhibitors in Oncology Patients</td>
</tr>
<tr>
<td>5.01.518</td>
<td>Bcr-Abl Kinase Inhibitors</td>
</tr>
<tr>
<td>5.01.534</td>
<td>Multiple Receptor Tyrosine Kinase Inhibitors</td>
</tr>
<tr>
<td>5.01.603</td>
<td>Epidermal Growth Factor Receptor (EGFR) Inhibitors</td>
</tr>
</tbody>
</table>

**Policy Guidelines**

N/A
Description

Prostate cancer is a neoplastic disease of the prostate gland. Prostate cancer arises from mutations in cells of the prostate that cause overexpression of enzymes that support androgen biosynthesis, loss of regulation of cell death within the tumor cells, and up regulation of androgen receptors. Androgen receptor binding by androgens plays a crucial role in prostate cancer progression. Most prostate cancers respond to androgen deprivation.

Approximately 60% of all cases of prostate cancer are diagnosed in men 65 years of age or older and 97% occur in men 50 and older. CRPC is a term used to describe prostate cancer which has progressed despite local therapy and first-line hormonal therapy assuring castrate levels of testosterone. Prostate cancers typically progress slowly and there is a high rate of survival for disease detected in early stages, but not for advanced disease stages. In the US, the 5-year survival rate is effectively 100% when the disease is local or regional, but this drops to 31% for disease with distant metastases.

Disease Burden

Prostate cancer is the second most common cause of cancer death in American men. In 2013, an estimated 238,590 men are expected to be diagnosed with prostate cancer, and approximately 29,720 are expected to have died from the disease. While it is prevalent, only 15% of all prostate cancer patients develop mCRPC prior to chemotherapy, and just 9% of all prostate cancer patients progress to mCRPC on first-line docetaxel chemotherapy.

The condition is associated with a substantial economic burden, due to high incidence rates and high costs associated with management of advanced cancer stages. The high management cost burden arises from the requirement for hospitalizations, chemotherapy, palliative surgical procedures, and computed tomography (CT) or magnetic resonance imaging (MRI) scans to monitor potential bone metastases. In 2007, per-patient per-month CRPC costs for men over the age of 40 were approximately $1,800, with ambulatory visits ($1,152) and inpatient stays ($559) comprising the majority of these costs. Total all-cause healthcare costs for these same patients totaled $3,500 per-patient per-month.

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 policy does not apply to Medicare Advantage.

Benefit Application

N/A

Rationale

Treatment Alternatives

Several approved pharmacotherapeutic alternatives for mCRPC have demonstrated some benefit in estimated
survival compared with acceptable controls.

**Abiraterone (Zytiga) + prednisone**

Abiraterone acetate is an oral drug that is converted *in vivo* to abiraterone, a CYP17 complex (17α-hydroxylase/C17,20-lyase) inhibitor that interrupts androgen biosynthesis throughout the body (testes, adrenal gland, and prostate tumor). Prostate cancer is very often an androgen-driven disease. CYP17 inhibition may also lead to increased mineralocorticoid production by the adrenal gland secondary to increased adrenocorticotropin hormone (ACTH) production from a feedback mechanism induced by low cortisol levels. Up-regulated ACTH leads to increased deoxycorticosterone which exhibits mineralocorticoid activity. Results from clinical trials have shown that coadministration of a corticosteroid (eg, prednisone) with abiraterone reduces the incidence and severity of mineralocorticoid excess associated adverse reactions. An RCT showed that abiraterone and prednisone improved radiographic progression-free survival, time to initiation of chemotherapy, time to onset or worsening of pain, and time to deterioration in improvement status.

**Enzalutamide (Xtandi®)**

Enzalutamide (Xtandi®) is indicated for the treatment of mCRPC in patients who have received prior chemotherapy containing docetaxel. One well-designed RCT has shown enzalutamide prolongs overall survival (OS) by 4.8 months, time to prostate-specific antigen (PSA) progression (TTPP), radiographic progression-free survival (rPFS), and time to first skeletal-related event (SRE) compared with placebo. There is currently no direct evidence with which to assess real world comparative effectiveness. Indirect evidence suggests a similar modest (2-5 month) increase in overall survival and hazard for risk of death with enzalutamide, abiraterone, or cabazitaxel in patients with mCRPC previously treated with a docetaxel-based regimen. However, it is important to note that the abiraterone and cabazitaxel studies had control arms which included agents with anti-tumor activity (prednisone and mitoxantrone + prednisone, respectively) compared to placebo control for enzalutamide. Evidence of safety is currently limited. The most significant toxicity reported for enzalutamide (Xtandi®) is seizure, although this occurs rarely (incidence about 1%).

Indirect evidence suggests favorable safety and tolerability compared to other second-line treatments with survival benefit for mCRPC. Enzalutamide lacks the detrimental effects of mineralocorticoid excess induced by abiraterone (Zytiga®), and thus does not require co-administration with corticosteroids, which may complicate CRPC treatment. Unlike cabazitaxel (Jevtana®), enzalutamide is not reported to commonly cause neuropathy or severe myelosuppression, two significant toxicities which can lead to morbidity and limit additional therapy in this patient population.

**Guideline Recommendations**

The latest prostate cancer guidelines from the NCCN recommend the following systemic therapies for advanced disease (primarily category 2a unless otherwise labeled):

**Metastatic castration-recurrent prostate cancer**

**General:** maintain castrate serum testosterone levels

**Bone metastases:** denosumab(1) or zoledronic acid(1)

**Asymptomatic visceral disease:** Sipuleucel-T or secondary hormone therapy (including abiraterone or enzalutamide) or docetaxel or clinical trial

**Symptomatic visceral disease:** Docetaxel or mitoxantrone (for patients not candidates for docetaxel) or abiraterone or enzalutamide or palliative care for symptomatic bone metastases or clinical trial

**Disease recurrence post-docetaxel or first-line therapy intolerance:** Abiraterone (1, post-docetaxel) or enzalutamide (1, post-docetaxel) or cabazitaxel (1, post-docetaxel) or salvage chemotherapy or docetaxel rechallenge or mitoxantrone or other secondary hormone therapy or sipuleucel-T* or clinical trial

**Disease recurrence post-abiraterone or enzalutamide or intolerance:** Docetaxel (1) or abiraterone or enzalutamide or Radium-223 for symptomatic bone metastases (1) or Sipuleucel-T* or other secondary hormone therapy or clinical trial.
Note: Sipuleucel-T (Provenge®) is recommended only for asymptomatic or minimally symptomatic patients with an ECOG performance status of 0-1. It is not indicated for patients with hepatic metastases or life expectancy <6 months.

These guidelines are generally aligned with evidence-based European guidelines, excepting the adoption of use of enzalutamide (Xtandi®).

National Comprehensive Cancer Network (NCCN) 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 (e.g., 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.

2014 Update
A search of the literature from 7/1/13 to 10/31/14 did not identify new evidence requiring changes to this policy.

2015 Update
Updated new indications and NCCN recommendations for enzalutamide (Xtandi®). A search of the literature from 7/1/14 to 8/31/15 did not identify new evidence requiring changes to this policy.

2016 Update
Updated policy based on new NCCN recommendations. Zytiga® step removed for Xtandi®.

References

8. Tannock IF, Berry WR, Horti J, et al. Docetaxel plus prednisone or mitoxantrone plus prednisone for


Appendix

N/A

History

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<tr>
<th>Date</th>
<th>Reason</th>
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<tbody>
<tr>
<td>04/09/13</td>
<td>New policy effective May 1, 2013. Add to Prescription Drug Section. Enzalutamide (Xtandi®) is approved for the treatment of prostate cancer when conditions are met.</td>
</tr>
<tr>
<td>07/08/13</td>
<td>Minor Update – Clarification was added to the policy that it is managed through the member’s pharmacy benefit; this is now listed in the header and within the coding section.</td>
</tr>
<tr>
<td>12/04/13</td>
<td>Replace policy. Policy section updated with the addition of abiraterone (Zytiga®), considered medically necessary for treating castration-resistant prostate cancer in combination with prednisone. (This was previously addressed in policy 5.01.540.) Rationale section updated in support of this addition.</td>
</tr>
<tr>
<td>12/08/14</td>
<td>Annual review. Policy updated with literature review; no change in policy statements</td>
</tr>
<tr>
<td>10/13/15</td>
<td>Annual Review. Updated enzalutamide (Xtandi®) for new indications.</td>
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<tr>
<td>12/08/15</td>
<td>Interim Update. Medical necessity coverage criteria for enzalutamide (Xtandi®) expanded.</td>
</tr>
<tr>
<td>10/25/16</td>
<td>Minor formatting update. Added second level bullet, Policy section under Enzalutamide (Xtandi®) criteria.</td>
</tr>
<tr>
<td>01/01/17</td>
<td>Annual review, changes approved December 13, 2016. Updated enzalutamide and abiraterone acetate for new indications. Medical necessity coverage criteria updated (Zytiga step removed).</td>
</tr>
<tr>
<td>05/01/17</td>
<td>Annual review, changes approved April 11, 2017. A statement outlining the length of therapy for initial and subsequent approval has been added to the policy.</td>
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</tbody>
</table>

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. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2017 Premera All Rights Reserved.