UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1112-12
Program	Prior Authorization/Notification
Medication	Tykerb® (lapatinib)
P&T Approval Date	8/2008, 6/2009, 9/2010, 12/2010, 9/2011, 8/2012, 7/2013, 11/2014, 11/2015, 9/2016, 9/2017, 9/2018, 9/2019, 9/2020, 10/2021, 10/2022, 10/2023, 10/2024
Effective Date	1/1/2025

1. Background:

Tykerb (lapatinib) is a kinase inhibitor indicated for use in combination with Femara® (letrozole) for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the human epidermal growth factor receptor 2 (HER2) receptor for whom hormonal therapy is indicated. Tykerb is also indicated in combination with Xeloda® (capecitabine) for treatment of patients with advanced or metastatic breast cancer whose tumors overexpress HER2 and who have received prior therapy, including an anthracycline, a taxane, and trastuzumab. Patients should have disease progression on trastuzumab prior to initiation of treatment with Tykerb in combination with Xeloda. The National Cancer Comprehensive Network (NCCN) also recommends the use of Tykerb in metastatic central nervous system (CNS) lesions with primary tumor of the breast, intracranial and spinal ependymomas, EGFR-positive chordoma, and colon and rectal cancers not previously treated with HER2 inhibitors.

Coverage Information:
Members will be required to meet the criteria below for coverage. For members under the age of 19 years, the prescription will automatically process without a coverage review.

Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances. Some states also mandate usage of other Compendium references. Where such mandates apply, they supersede language in the benefit document or in the notification criteria.

2. Coverage Criteria[a]:

A. <u>Patients less than 19 years of age</u>

1. **Tykerb** will be approved based on the following criterion:

   a. Patient is less than 19 years of age

Authorization will be issued for 12 months.

B. <u>Breast Cancer</u>

1. **<u>Initial Authorization</u>**

   a. **Tykerb** will be approved based on **<u>one</u>** of the following criteria:

(1) **All** of the following:

(a) Diagnosis of recurrent unresectable (local or regional) or stage IV breast cancer

-AND-

(b) Disease is hormone receptor positive and human epidermal growth factor receptor 2-positive (HER2+)

-AND-

(c) Used in combination with an aromatase inhibitor [e.g., Aromasin (exemestane), Femara (letrozole), Arimidex (anastrozole)]

-OR-

(2) **All** of the following:

(a) **One** of the following:

i. Diagnosis of recurrent unresectable (local or regional) or stage IV breast cancer
ii. Breast cancer that is unresponsive to preoperative systemic therapy

-AND-

(b) Disease is HER2+

-AND-

(c) Used as fourth line therapy and beyond in combination with **one** of the following:

i. Herceptin (trastuzumab)
ii. Xeloda (capecitabine)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Tykerb** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Tykerb therapy

Authorization will be issued for 12 months.

C. Central Nervous System (CNS) Cancers

1. **Initial Authorization**

a. **Tykerb** will be approved based on **one** of the following criteria:

(1) **All** of the following:

(a) Diagnosis of recurrent, central nervous system (CNS) cancer with metastatic lesions

-AND-

(b) Tykerb is active against primary (breast) tumor

-AND-

(c) Used in combination with Xeloda (capecitabine)

-OR-

(2) **All** of the following:

(a) Diagnosis of progressive or recurrent intracranial or spinal ependymoma (excluding subependymoma)

-AND-

(b) Patient has received previous radiation therapy

-AND-

(c) **One** of the following:

i. Patient has received gross total or subtotal resection with negative cerebrospinal fluid (CSF) cytology
ii. Patient has received subtotal resection and evidence of metastasis (brain, spine, or CSF)
iii. Patient has unresectable disease

-AND-

(d) Used in combination with Temodar (temozolomide)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Tykerb** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Tykerb therapy

Authorization will be issued for 12 months.

D. Chordoma

1. **Initial Authorization**

   a. **Tykerb** will be approved based on **both** of the following criteria:

      (1) Diagnosis of recurrent conventional or chondroid chordoma

      -AND-

      (2) Disease is EGFR-positive

   Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Tykerb** will be approved based on the following criterion:

      (1) Patient does not show evidence of progressive disease while on Tykerb therapy

   Authorization will be issued for 12 months.

E. Colon Cancer

1. **Initial Authorization**

   a. **Tykerb** will be approved based on **all** of the following criteria:

      (1) Diagnosis of colon cancer

      -AND-

      (2) Disease is HER2-amplified and RAS and BRAF wild-type

      -AND-

      (3) **One** of the following:

         (a) Disease is proficient mismatch repair/microsatellite-stable (pMMR/MSS)

         -OR-

         (b) **Both** of the following:

            i. Disease is positive for deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) or polymerase epsilon/delta (POLE/POLD1) mutation

            -AND-

ii. **One** of the following:

- Ineligible for or progressed on checkpoint inhibitor immunotherapy [e.g., Opdivo (nivolumab), Keytruda (pembrolizumab), Jemperli (dostarlimab-gxly)]
- Has a contraindication to checkpoint inhibitor immunotherapy

-AND-

(4) **One** of the following:

(a) **Both** of the following:

i. Used as initial therapy for unresectable metachronous metastases
ii. Previous therapy with FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or CapeOX (capecitabine and oxaliplatin) within the past 12 months

-OR-

(b) Intensive chemotherapy with **one** of the following is not recommended:

i. Oxaliplatin
ii. Irinotecan
iii. Capecitabine

-OR-

(c) Used as second-line and subsequent therapy for progression of advanced or metastatic disease

-AND-

(5) Used in combination with trastuzumab

-AND-

(6) Patient has not previously been treated with a HER2 inhibitor [e.g., trastuzumab, Perjeta (pertuzumab), Nerlynx (neratinib)]

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Tykerb** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Tykerb therapy

Authorization will be issued for 12 months.

F. Rectal Cancer

1. **Initial Authorization**

a. **Tykerb** will be approved based on **all** of the following criteria:

(1) Diagnosis of rectal cancer

-AND-

(2) Disease is HER2-amplified and RAS and BRAF wild-type

-AND-

(3) **One** of the following:

(a) Disease is proficient mismatch repair/microsatellite-stable (pMMR/MSS)

-OR-

(b) Disease is positive for deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) or polymerase epsilon/delta (POLE/POLD1) mutation and **one** of the following:

i. Ineligible for or progressed on checkpoint inhibitor immunotherapy [e.g., Opdivo (nivolumab), Keytruda (pembrolizumab), Jemperli (dostarlimab-gxly)]
ii. Has a contraindication to checkpoint inhibitor immunotherapy

-AND-

(4) **One** of the following:

(a) **Both** of the following:

i. Used as initial therapy for unresectable metachronous metastases
ii. Previous therapy with FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or CapeOX (capecitabine and oxaliplatin) within the past 12 months

-OR-

(b) Intensive chemotherapy with **one** of the following is not recommended:

i. Oxaliplatin
ii. Irinotecan
iii. capecitabine

-OR-

(c) Used as second-line and subsequent therapy for progression of advanced or metastatic disease

-AND-

(5) Used in combination with trastuzumab

-AND-

(6) Patient has not previously been treated with a HER2 inhibitor [e.g., trastuzumab, Perjeta (pertuzumab), Nerlynx (neratinib)]

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Tykerb** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Tykerb therapy

Authorization will be issued for 12 months.

G. NCCN Recommended Regimens

The drug has been recognized for treatment of the cancer indication by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limit may be in place.

4. References:

1. Tykerb [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corp.; March 2022.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org. Accessed August 28, 2024.

Program	Prior Authorization/Notification –Tykerb® (lapatinib)
Change Control	
11/2014	Annual review. Added coverage criteria for chordoma. Updated background & references.
11/2015	Annual review. Increased authorization from 7 months to 12 months. Revised breast cancer & CNS cancer criteria. Updated background & references.
9/2016	Annual review. Changed Member to Patient. Revised breast cancer criteria. Updated references.
9/2017	Annual review. Updated references.
9/2018	Annual review. Updated coverage criteria for breast cancer. Updated references.
9/2019	Annual review. Updated coverage criteria to align with NCCN guidelines. Updated references. Added general NCCN recommended review criteria.
9/2020	Annual review. No changes to coverage criteria.
10/2021	Annual review. Updated coverage criteria for rectal cancer to align with NCCN guidelines. Updated references.
10/2022	Annual review. Updated coverage criteria for colon cancer to align with NCCN guidelines. Added state mandate. Updated references.
10/2023	Annual review. Updated coverage criteria for colon cancer.
10/2024	Annual review. Updated coverage criteria for breast cancer, central nervous system cancers, chordoma, colon cancer, and rectal cancer per NCCN guidelines.