UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2023 P 1124-14
Program	Prior Authorization/Notification
Medication	Imbruvica® (ibrutinib)
P&T Approval Date	2/2014, 2/2015, 4/2015, 4/2016, 3/2017, 9/2017, 9/2018, 9/2019, 9/2020, 10/2021, 10/2022, 10/2023
Effective Date	1/1/2024

1. Background:

Imbruvica® (ibrutinib) is a kinase inhibitor indicated for the treatment of adult patients with the following: chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL); chronic lymphocytic leukemia (CLL)/SLL with 17p deletion; and Waldenström's macroglobulinemia (WM). Imbruvica is also FDA approved for the treatment of adult and pediatric patients age 1 year and older with chronic graft versus host disease (cGVHD) after failure of one or more lines of systemic therapy.[1]

The National Cancer Comprehensive Network (NCCN) also recommends the use of Imbruvica for the B-cell lymphoma types: extranodal marginal zone lymphoma (EMZL) of the stomach and of nongastric sites (noncutaneous), mantle cell lymphoma (MCL), diffuse large B-cell, HIV-related B-cell, high grade B-cell lymphoma, and post-transplant lymphoproliferative disorders. NCCN also recommends its use for primary CNS lymphoma and hairy cell leukemia.[2]

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. **Imbruvica** 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>B-Cell Lymphoma</u>

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

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

      i. **<u>Both</u>** of the following:

         (a) Diagnosis of mantle cell lymphoma (MCL)

-AND-

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

i. Patient has received at least one prior therapy for MCL
ii. Used in pre-treatment therapy in combination with Rituxan (rituximab) to limit the number of cycles with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen

-OR-

ii. Diagnosis of **one** of the following:

(a) Chronic Lymphocytic Leukemia (CLL)
(b) Small Lymphocytic Lymphoma (SLL)

-OR-

iii. **Both** of the following:

(a) Diagnosis of **one** of the following:

i. Histologic transformation to diffuse large B-cell lymphoma
ii. Post-transplant lymphoproliferative disorders
iii. Extranodal marginal zone lymphoma (EMZL) of the stomach
iv. Extranodal Marginal Zone Lymphoma of Nongastric Sites (Noncutaneous)
v. Diffuse large B-cell lymphoma (non-GCB DLBCL and non-candidate for transplant)
vi. HIV-related B-cell lymphoma
vii. High grade B-cell lymphoma
viii. Hairy cell leukemia
ix. Nodal or splenic marginal zone lymphoma (MZL)

-AND-

(b) Used as second-line or a subsequent therapy

Authorization will be issued for 12 months.

2. **Reauthorization**

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

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

Authorization will be issued for 12 months.

C. Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma

1. **Initial Authorization**

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

      (1) Diagnosis of Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma

      Authorization will be issued for 12 months.

2. **Reauthorization**

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

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

      Authorization will be issued for 12 months.

D. Chronic Graft Versus Host Disease

1. **Initial Authorization**

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

      (1) Diagnosis of chronic graft versus host disease

      -AND-

      (2) History of failure of at least one other systemic therapy [e.g., corticosteroids, mycophenolate, etc.]

      Authorization will be issued for 12 months.

2. **Reauthorization**

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

      (1) Patient shows evidence of positive clinical response while on Imbruvica therapy

      Authorization will be issued for 12 months.

E. Primary CNS Lymphoma

1. **Initial Authorization**

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

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

(a) Diagnosis of primary CNS lymphoma

-AND-

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

i. Used as second-line or a subsequent therapy
ii. Used as induction therapy if patient is unsuitable or intolerant to high-dose methotrexate

Authorization will be issued for 12 months.

2. **Reauthorization**

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

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

Authorization will be issued for 12 months.

F. 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 limits may be in place.

4. References:

1. Imbruvica [package insert]. South San Francisco, CA: Pharmacyclics, LLC. May 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at https://www.nccn.org/compendia-templates/compendia/drugs-and-biologics-compendia. Accessed August 31, 2023.

Program	Prior Authorization/Notification - Imbruvica (ibrutinib)
Change Control	
2/2014	New program for Imbruvica approved by FDA on 11/13/2013.
9/2014	Administrative change - Tried/Failed exemption for State of New Jersey removed.
2/2015	Annual review. Added coverage for CLL with del(17p). Updated background and references.
4/2015	Off-cycle review. Revised CLL/SLL and WM/Lymphoplasmacytic Lymphoma per updated PI & NCCN.
4/2016	Annual review. Moved MCL, CLL and SLL criteria under the general diagnosis of NHL. Updated references.
3/2017	Annual review. Added coverage for Marginal Zone Lymphoma (MZL). Updated background and references.
9/2017	Added new indication of chronic graft versus host disease. Updated background and references.
9/2018	Annual review. Revised coverage criteria. Added coverage for B-Cell lymphoma types and CNS lymphoma. Updated background and references.
9/2019	Annual review. Updated lymphoma based on NCCN guidelines. Updated references. Added general NCCN recommended review criteria.
3/2020	Administrative change to correct formatting/numbering.
9/2020	Annual review. Updated lymphoma criteria based on NCCN guidelines. Updated background and references.
10/2021	Annual review. No changes to coverage criteria. Updated references.
10/2022	Annual review. Updated background with approval for chronic graft-versus-host disease (cGVHD) for pediatric patients per prescribing information. Removed coverage for Follicular Lymphoma (grade 1-2) as no longer recommended by NCCN guidelines. Administrative change to correct formatting/numbering. Added state mandate. Updated references.
10/2023	Annual review. Updated background with withdrawal of MCL and MZL indications from FDA label as well as NCCN recommendations. Updated B-Cell lymphomas with terminology changes. Updated references.