UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2023 P 1169-9
Program	Prior Authorization/Notification
Medication	Lonsurf® (trifluridine/tipiracil)
P&T Approval Date	11/2015, 9/2016, 9/2017, 9/2018, 4/2019, 4/2020, 4/2021, 4/2022, 4/2023
Effective Date	7/1/2023; Oxford only: 7/1/2023

1. Background:

Lonsurf (trifluridine/tipiracil) is a combination of trifluridine, a nucleoside metabolic inhibitor, and tipiracil, a thymidine phosphorylase inhibitor, indicated for the treatment of adult patients with:

- Metastatic colorectal cancer who have been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF biological therapy, and if RAS wild-type, an anti-EGFR therapy.
- Metastatic gastric or gastroesophageal junction adenocarcinoma previously treated with at least two prior lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate HER2/neu-targeted therapy.

In addition, the National Cancer Comprehensive Network (NCCN) also recommends the use of Lonsurf for the treatment of colorectal cancer as a single agent or in combination with bevacizumab for advanced or metastatic disease not previously treated with Lonsurf in patients who have progressed through all available regimens besides Stivarga or Lonsurf

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,b]:

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

1. **Lonsurf** 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>Colorectal Cancer</u>

1. **Lonsurf** will be approved based on **<u>all</u>** of the following criteria:

   a. Diagnosis of metastatic colorectal cancer (mCRC)

-AND-

b. History of failure, contraindication, or intolerance to treatment with **all** of the following:

(1) Fluoropyrimidine-based chemotherapy
(2) Oxaliplatin-based chemotherapy
(3) Irinotecan-based chemotherapy
(4) Anti-VEGF biological therapy

-AND-

c. **One** of the following:

(1) Tumor is *RAS* mutant-type

-OR-

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

(a) Tumor is *RAS* wild-type
(b) History of failure, contraindication, or intolerance to anti-EGFR therapy

Authorization will be issued for 12 months.

2. **Reauthorization**

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

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

Authorization will be issued for 12 months.

C. Gastric/Gastroesophageal Junction Adenocarcinoma

1. **Lonsurf** will be approved based on **both** of the following criteria:

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

(1) Metastatic gastric cancer
(2) Metastatic gastroesophageal junction adenocarcinoma

-AND-

b. History of failure, contraindication, or intolerance to treatment with at least **two** prior lines of chemotherapy that consisted of the following agents:

(1) Fluoropyrimidine (e.g, fluorouracil)
(2) Platinum (e.g., carboplatin, cisplatin, oxaliplatin)
(3) Taxane (e.g, docetaxel, paclitaxel) or irinotecan

(4) HER2/neu-targeted therapy (e.g., trastuzumab) (if HER2 overexpression)

Authorization will be issued for 12 months.

2. **Reauthorization**

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

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

Authorization will be issued for 12 months.

D. 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

[b] Coverage of oncology medications may be approved based on state mandates.

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. Lonsurf [package insert]. Cambridge, MA: ARIAD Pharmaceuticals, Inc.; December 2019.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at https://www.nccn.org/professionals/drug_compendium/content/. Accessed February 24, 2023.

Program	Prior Authorization/Notification - Lonsurf (trifluridine/tipiracil)
Change Control	
11/2015	New program.
9/2016	Annual review. Updated references.
9/2017	Annual review. Updated references.
9/2018	Annual review. Updated references.
4/2019	Added coverage for metastatic gastric cancer. Updated references.
4/2020	Annual review. Added general NCCN recommendations for use criteria. Updated reference.
4/2021	Annual review with no changes to coverage criteria. Updated background and references.

4/2022	Annual review. Updated references.
4/2023	Annual review. Added state mandate and oncology medications footnote. Updated references.