Clinical Policy: Fostamatinib (Tavalisse)

Reference Number: CP.PHAR.24
Effective Date: 06.05.18
Last Review Date: 02.19
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Fostamatinib (Tavalisse™) is an oral spleen tyrosine kinase inhibitor.

FDA Approved Indication(s)

Tavalisse is indicated for the treatment of thrombocytopenia in adult patients with chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® Tavalisse is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Immune Thrombocytopenia (must meet all)**:**

1. Diagnosis of chronic ITP;
2. Prescribed by or in consultation with a hematologist;
3. Age ≥ 18 years;
4. Current (within 30 days) platelet count < 30,000/µL or member has an active bleed;
5. Failure of systemic corticosteroids and immune globulins, unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);
   **Prior authorization may be required for immune globulins*
6. Dose does not exceed 300 mg/day (2 tablets/day).

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Chronic Immune Thrombocytopenia (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;

2. Member is responding positively to therapy (e.g., increase in platelet count from baseline, reduction in bleeding events);
3. If request is for a dose increase, new dose does not exceed 300 mg/day (2 tablets/day).

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
ITP: immune thrombocytopenia

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Corticosteroids*		
dexamethasone	Oral dosage: Initially, 0.75 to 9 mg/day POin 2 to 4 divided doses. Adjust according to patient response Intramuscular or intravenous dosage: Initially, 0.5 to 9 mg/day IV or IM in 2 to 4 divided doses. Adjust according to patient response	Highly variable depending on the nature and severity of the disease, route of treatment, and on patient response.
methylprednisolone	10-40 mg IV every 4-6 hours for up to 72 hours	
prednisone	Initially, 1 mg/kg PO once daily; however, lower doses of 5 mg/day to 10 mg/day PO are preferable for long-term	

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	treatment	
Immune globulins		
Immune globulins (e.g., Carimune® NF, Flebogamma® DIF 10%, Gammagard® S/D, Gammaked™, Gamunex®-C, Gammaplex®, Octagam® 10%, Privigen®, etc.)	Refer to prescribing information	Refer to prescribing information

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
Examples of corticosteroids provided are not all inclusive

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information
- Definitions of acute v. chronic ITP:
  - Per an International Working Group consensus panel of ITP experts, ITP is defined as newly diagnosed (diagnosis to 3 months), persistent (3 to 12 months from diagnosis), or chronic (lasting for more than 12 months). Although not formally validated, these definitions are supported and used by the American Society of Hematology (ASH).
- Per the 2011 ASH guidelines, response to treatment was defined by the following:
  - A response would be defined as a platelet count ≥ 30,000/µL and a greater than 2-fold increase in platelet count from baseline measured on 2 occasions > 7 days apart and the absence of bleeding.
  - A failure would be defined as a platelet count < 30,000/µL or a less than 2-fold increase in platelet count from baseline or the presence of bleeding. Platelet count must be measured on 2 occasions more than a day apart.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
ITP	100 mg PO BID; after 4 weeks, increase to 150 mg BID, if needed, to achieve platelet counts of at least 50 x 10^9/L	300 mg/day

VI. Product Availability
Tablet: 100 mg, 150 mg

VII. References

1. Tavalisse Prescribing Information. San Francisco, CA: Rigel Pharmaceuticals Inc.; April 2018. Available at: www.Tavalisse.com. Accessed October 30, 2018.
2. Bussel J, Arnold DM, Grossbard E, et al. Fostamatinib for the treatment of adult persistent and chronic immune thrombocytopenia: results of two phase 3, randomized, placebo-controlled trials. American Journal of Hematology 2018;93(7):921-930. doi: 10.1002/ajh.25125.
3. Khan AM, Halina M, and Nevarez A. Clinical practice updates in the management of immune thrombocytopenia. P&T 2017;42(12):756-763.
4. Bussel J, Arnold DM, Cooper N, et al. Long-term maintenance of platelet responses in adults with persistent/chronic immune thrombocytopenia treated with fostamatinib: 1-year efficacy and safety results [abstract]. Blood 2017;130:16.
5. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2018. Available at: http://www.clinicalpharmacology-ip.com/.
6. George JN, Woolf SH, Raskob GE, et al. Idiopathic thrombocytopenic purpura: a practice guidelines developed by explicit methods for the American Society of Hematology. Blood 1996;88(1):3-40.
7. Neunert C, Lim W, Crowther M, et al. The American Society of Hematology 2011 evidence-based practice guideline for immune thrombocytopenia. Blood 2011;117(16):4190-4207.
8. Portielje JEA, Westendorp RGJ, Kluin-Nelemans HC, Brand A. Morbidity and mortality in adults with idiopathic thrombocytopenic purpura. Blood 2001;97(9):2549-2554.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	06.05.18	08.18
Removed requirement related to splenectomy based on specialist feedback.	08.20.18	11.18
1Q 2019 annual review: added HIM line of business; for platelet count requirement, corrected ≤ to < per guidelines; added requirement that initial platelet counts be current (within 30 days); no significant changes; references reviewed and updated.	10.30.18	02.19

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy; HIM.PA.103.