Cetuximab (Erbitux®)

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications

1. Squamous Cell Carcinoma of the Head and Neck (SCCHN)
   Erbitux is indicated:
   a. In combination with radiation therapy for the initial treatment of locally or regionally advanced squamous cell carcinoma of the head and neck (SCCHN).
   b. In combination with platinum-based therapy with fluorouracil for the first-line treatment of patients with recurrent locoregional disease or metastatic SCCHN.
   c. As a single agent for the treatment of patients with recurrent or metastatic SCCHN for whom prior platinum-based therapy has failed.

2. K-Ras Wild-type, EGFR-expressing Colorectal Cancer (CRC)
   Erbitux is indicated for the treatment of K-Ras wild-type, epidermal growth factor receptor (EGFR)-expressing, metastatic colorectal cancer (mCRC) as determined by an FDA-approved test:
   a. In combination with FOLFIRI (irinotecan, fluorouracil, leucovorin) for first-line treatment,
   b. In combination with irinotecan in patients who are refractory to irinotecan-based chemotherapy,
   c. As a single agent in patients who have failed oxaliplatin- and irinotecan-based chemotherapy or who are intolerant to irinotecan.

   Limitations of Use:
   Erbitux is not indicated for treatment of Ras-mutant colorectal cancer or when the results of the Ras mutation tests are unknown.

3. BRAF V600E Mutation-Positive Metastatic Colorectal Cancer (CRC)
   Erbitux is indicated, in combination with encorafenib, for the treatment of adult patients with metastatic colorectal cancer (CRC) with a BRAF V600E mutation, as detected by an FDA-approved test, after prior therapy.

B. Compendial Uses

1. Colorectal cancer
2. Squamous cell carcinoma of the head and neck
3. Occult primary head and neck cancer
4. Penile cancer

5. Squamous cell skin cancer
6. Non-small cell lung cancer

All other indications are considered experimental/investigational and not medically necessary.

II. DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:

A. Documentation of RAS wild-type status or KRAS G12C mutation, where applicable.
B. Documentation of BRAF mutation status, where applicable.
C. Documentation of EGFR expression, where applicable.

III. CRITERIA FOR INITIAL APPROVAL

A. Colorectal Cancer

Authorization of 6 months may be granted for treatment of colorectal cancer, including appendiceal adenocarcinoma and anal adenocarcinoma, for unresectable/inoperable, advanced, or metastatic disease and the member has not previously experienced clinical failure on panitumumab when either of the following criteria are met:

1. The member meets all of the following criteria:
   i. The *RAS (KRAS and NRAS)* mutation status is negative (wild-type)
   ii. If the tumor is positive for BRAF V600E mutation, the requested medication will be used in combination with encorafenib (Braftovi)
   iii. For first-line treatment of colon cancer, the tumor is left-sided only; or
2. The member meets all of the following criteria:
   i. The disease is KRAS G12C mutation positive
   ii. The requested medication will be used in combination with sotorasib (Lumakras) or adagrasib (Krazati)
   iii. The member previously received treatment with chemotherapy

B. Squamous Cell Carcinoma of the Head and Neck

Authorization of 6 months may be granted for treatment of squamous cell carcinoma of the head and neck when any of the following criteria is met:

1. Disease is locally or regionally advanced, unresectable, recurrent, persistent, or metastatic.
2. Member is unfit for surgery.
3. The requested medication will be used in combination with radiation.

C. Occult Primary Head and Neck Cancer

Authorization of 6 months may be granted as a single agent for treatment of occult primary head and neck cancer for chemoradiation.

D. Penile Cancer

Authorization of 6 months may be granted as a single agent for subsequent treatment of metastatic penile cancer.

E. Squamous Cell Skin Cancer

Authorization of 6 months may be granted as a single agent for treatment of squamous cell skin cancer in unresectable/inoperable/incompletely resected, locally advanced, regional, recurrent, or distant metastatic disease.

F. Non-Small Cell Lung Cancer (NSCLC)

Authorization of 6 months may be granted for subsequent treatment of recurrent, advanced or metastatic NSCLC when all of the following criteria are met:

1. The requested medication will be used in combination with afatinib (Gilotrif).
2. The requested medication will be used in members with a known sensitizing EGFR mutation (e.g., EGFR exon 19 deletion or L858R mutation, or EGFR S768I, L861Q, and/or G719X mutation) following disease progression on EGFR tyrosine kinase inhibitor therapy.

IV. CONTINUATION OF THERAPY

Authorization of 6 months may be granted for continued treatment in members requesting reauthorization for an indication listed in Section III when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

REFERENCES

1. Erbitux [package insert]. Branchburg, NJ: ImClone LLC; September 2021.
2. The NCCN Drugs & Biologics Compendium® © 2024 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed September February 6, 2024.
3. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines): Colon Cancer. Version 1.2024. Accessed February 6, 2024. https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf
4. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines): Anal Carcinoma. Version 3.2023. Accessed September 22, 2023 https://www.nccn.org/professionals/physician_gls/pdf/anal.pdf

EFFECTIVE DATE 7/2/2024

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