PHARMACY COVERAGE GUIDELINES
SECTION: DRUGS

ORIGINAL EFFECTIVE DATE: 8/19/2021
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ARCHIVE DATE:

TRUSELTIQ™ (infigratinib) oral

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. **All requested data must be provided.** Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

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Criteria:

- **Criteria for initial therapy:** Truseltiq (infigratinib) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with an Oncologist

  2. Individual is 18 years of age or older

  3. A confirmed diagnosis of **ONE** of the following:
     a. Previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other FGFR genetic alterations

     b. Other request for a specific oncologic direct treatment use that is found and listed in the National Comprehensive Cancer Network (NCCN) Guidelines with Categories of Evidence and Consensus of 1 and 2A

  4. **ALL** of the following **baseline tests** have been completed before initiation of treatment with continued monitoring as clinically appropriate:
     a. Ophthalmic examination including optical coherence tomography (OCT)
     b. There is a negative pregnancy test in a woman of child bearing potential
     c. Eastern Cooperative Oncology Group (ECOG) Performance Status of 0 or 1

  5. There are no significant interacting drugs

  6. Individual has **NONE** of the following:
     a. Severe renal impairment (CrCl less than 30 mL/min) or end-stage renal disease receiving intermittent hemodialysis
     b. Severe hepatic impairment (total bilirubin greater than 3-times the upper limit of normal with any aspartate aminotransferase (AST)

  Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Truseltiq (infigratinib) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with an Oncologist

  2. Individual's condition has responded while on therapy
     a. Response is defined as:
        i. No evidence of disease progression
        ii. No evidence individual has developed any significant unacceptable adverse drug reactions that may exclude continued use

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3. Individual has been adherent with the medication

4. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use
    a. Significant adverse effect such as:
        i. Ocular toxicity such as Retinal Pigment Epithelial Detachment (RPED)
        ii. Hyperphosphatemia causing soft tissue mineralization, cutaneous calcinosis, non-uremic calciphylaxis, vascular calcification, and myocardial calcification

5. There are no significant interacting drugs

6. Individual has **NONE** of the following:
    a. Severe renal impairment (CrCl less than 30 mL/min) or end-stage renal disease receiving intermittent hemodialysis
    b. Severe hepatic impairment (total bilirubin greater than 3-times the upper limit of normal with any aspartate aminotransferase (AST)

Renewal duration: 12 months

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

    1. **Off-Label Use of a Non-cancer Medications**

    2. **Off-Label Use of a Cancer Medication for the Treatment of Cancer without a Specific Coverage Guideline**

Description:

Truseltiq (infigratinib) is a kinase inhibitor indicated for the treatment of adults with previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test. This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).

Resources:

Truseltiq (infigratinib) product information, revised by QED Therapeutics, Inc. 05-2021. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed on August 04, 2021.

Stuart KE. Systemic therapy for advanced cholangiocarcinoma. In: UpToDate, Goldber RM, Savarese DMF (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Accessed on August 04, 2021.

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National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Hepatobiliary Cancers Version 3.2021 – Updated June 15, 2021. Available at https://www.nccn.org. Accessed on August 04, 2021.

Off Label Use of Cancer Medications: A.R.S. §§ 20-826(R) & (S). Subscription contracts; definitions.

Off Label Use of Cancer Medications: A.R.S. §§ 20-1057(V) & (W). Evidence of coverage by health care service organizations; renewability; definitions.