

Clinical Policy: Gilteritinib (Xospata)

Reference Number: IL.PHAR.412

Effective Date: 1.1.20

Last Review Date: 4.28.22

Line of Business: Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Gilteritinib (Xospata[®]) is a tyrosine kinase inhibitor.

FDA Approved Indication(s)

Xospata is indicated for the treatment of adult patients who have relapsed or refractory acute myeloid leukemia (AML) with a FMS-like tyrosine kinase 3 (FLT3) mutation as detected by an FDA-approved test.

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[®] that Xospata is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Acute Myeloid Leukemia (must meet all):

1. Diagnosis of relapsed or refractory AML;
2. Documentation of the presence of an FLT3 mutation;
3. Prescribed by or in consultation with an oncologist or hematologist;
4. Age \geq 18 years
5. For Xospata request, medical justification supports inability to use gilteritinib, if available, (e.g., contraindications to excipients);
6. Prescribed as subsequent therapy following failure of FLT3 targeted regimens (e.g., Nexavar[®] (sorafenib)-containing regimens), unless contraindicated or clinically significant adverse effects are experienced;
**Prior authorization may be required for FLT3 targeted regimens*
7. Request meets one of the following (a or b):
 - a. Dose does not exceed 120 mg (3 tablets) per day.
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:

Medicaid – 6 months

B. Myeloid/Lymphoid Neoplasm with Eosinophilia (off-label) (must meet all):

1. Diagnosis of a myeloid/lymphoid neoplasm with eosinophilia (MLNE);

2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age \geq 18 years;
4. For Xospata request, medical justification supports inability to use gilteritinib, if available, (e.g., contraindications to excipients);
5. Documentation of an FLT3 mutation;
6. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).*

*Prescribed regimen must be FDA-approved or recommended by NCCN

Approval duration:

Medicaid/HIM – 6 months

Commercial – Length of Benefit

C. 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.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Xospata for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Xospata request, medical justification supports inability to use gilteritinib, if available, (e.g., contraindications to excipients);
4. If request is for a dose increase, request meets one of the following (a or b):
 - a. Dose does not exceed 120 mg (3 tablets) per day.
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:

Medicaid – 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.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.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AML: acute myeloid leukemia

FDA: Food and Drug Administration

NCCN: National Comprehensive Cancer Network

FLT3: FMS-like tyrosine kinase 3MLNE: myeloid/lymphoid neoplasm with eosinophilia

Appendix B: Contraindications/Boxed Warnings

- Contraindication(s): hypersensitivity to Xospata or any of the excipients
- Boxed warning(s): differentiation syndrome

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
AML	120 mg PO QD	120 mg/day

VI. Product Availability

Tablets: 40 mg

VII. References

1. Xospata Prescribing Information. Northbrook, IL: Astella Pharma US, Inc.; May 2019. Available at www.xospata.com. Accessed October 12, 2020.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed October 12, 2020.
3. National Comprehensive Cancer Network. Acute Myeloid Leukemia Version 4.2020. Available at: http://www.nccn.org/professionals/physician_gls/pdf/aml.pdf. Accessed October 12, 2020.
4. National Comprehensive Cancer Network. Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes Version 3.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/mlne.pdf. Accessed October 12, 2020.
5. National Comprehensive Cancer Network. Acute Lymphoblastic Leukemia Version 1.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/all.pdf. Accessed October 12, 2020.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created, adapted CP.PHAR.412 Gilteritinib (Xospata) policy.	12.11.19	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2020 annual review: Nexavar added as a prior therapy option given unique place in FLT3 therapy per NCCN; references reviewed and updated.	12.30.19	1.7.20
2Q 2021 annual review: oral oncology generic redirection language added; MLNE NCCN recommended use added	4.14.2021	
2Q 2022 annual review: MLNE added to abbreviations and acronyms, reference reviewed and updated	4.28.22	

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 non-formulary policy; HIM.PA.103.

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