Clinical Policy: Abiraterone (Zytiga, Yonsa)

Reference Number: CP.PHAR.84
Effective Date: 10.01.11
Last Review Date: 02.24
Line of Business: Commercial, HIM, Medicaid

Revision Log

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

Description

Abiraterone (Zytiga®, Yonsa®) is a selective and irreversible inhibitor of enzyme CYP17.

FDA Approved Indication(s)

Zytiga is indicated in combination with prednisone for the treatment of metastatic castration-resistant prostate cancer and metastatic high-risk castration-sensitive prostate cancer.

Yonsa is indicated in combination with methylprednisolone for the treatment of patients with metastatic castration-resistant prostate cancer.

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 Zytiga and Yonsa are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Prostate Cancer (must meet all)**:**

1. Diagnosis of one of the following (a or b):
   a. Metastatic prostate cancer;
   b. Non-metastatic prostate cancer with prostate-specific antigen (PSA) persistence (defined as failure of PSA to fall to undetectable levels) or recurrence (defined as undetectable PSA with a subsequent detectable PSA that increases on 2 or more determinations or that increases to PSA > 0.1 ng/mL) after radical prostatectomy and life expectancy > 5 years (off-label);
2. Prescribed by or in consultation with an oncologist or urologist;
3. Age ≥ 18 years;
4. For brand Zytiga and brand Yonsa requests: member must use generic abiraterone, unless contraindicated or clinically significant adverse effects are experienced;
5. Prescribed concurrently with a gonadotropin-releasing hormone (GnRH) analog or member has had a bilateral orchiectomy;
6. If prescribed concurrently with Lynparza® or Zejula®, request is for metastatic castration-resistant prostate cancer;
   ** Prior authorization may be required for Lynparza and Zejula*
7. For Zytiga requests: prescribed in combination with prednisone or dexamethasone;

8. For Yonsa requests: prescribed in combination with methylprednisolone or dexamethasone;
9. Request meets one of the following (a, b, or c):*
   a. Zytiga: Dose does not exceed 1,000 mg once daily, or 1,000 mg twice daily if prescribed concomitantly with a strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, and phenobarbital);
   b. Yonsa: Dose does not exceed 500 mg (4 tablets) per day, or 500 mg twice daily (8 tablets) if prescribed concomitantly with a strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, and phenobarbital);
   c. Dose 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 – 12 months or duration of request, whichever is less

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Prostate Cancer (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Zytiga or Yonsa for metastatic prostate cancer and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For brand Zytiga and brand Yonsa requests: member must use generic abiraterone, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, request meets one of the following (a, b, or c):*
   a. Zytiga: New dose does not exceed 1,000 mg once daily, or 1,000 mg twice daily if prescribed concomitantly with a strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, and phenobarbital);

b. Yonsa: New dose does not exceed 500 mg (4 tablets) per day, or 500 mg twice daily (8 tablets) if prescribed concomitantly with a strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, and phenobarbital);
c. New dose 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 – 12 months
Commercial – 12 months or duration of request, whichever is less

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 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, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ADT: androgen deprivation therapy
CRPC: castration-resistant prostate cancer
CSPC: castration-sensitive prostate cancer
CYP17: cytochrome 17 α-hydroxylase/C17,20-lyase
FDA: Food and Drug Administration
LHRH: luteinizing hormone-releasing hormone

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information

- CRPC is prostate cancer that progresses clinically, radiographically, or biochemically despite castrate levels of serum testosterone (< 50 ng/dL). Per the NCCN, androgen deprivation therapy (ADT) should be continued in the setting of CRPC while additional therapies are applied.
- Examples of ADT include:
  - Bilateral orchiectomy (surgical castration)
  - Luteinizing hormone-releasing hormone (LHRH) agonist given with or without an anti-androgen:
    - LHRH agonists: Zoladex® (goserelin), Vantas® (histrelin), leuprolide (Lupron Depot®, Eligard®), and Trelstar® (triptorelin)
    - Anti-androgens: bicalutamide (Casodex®), flutamide, nilutamide (Nilandron®), Xtandi® (enzalutamide), Erleada® (apalutamide)
  - LHRH antagonist: Firmagon® (degarelix), Orgovyx® (relugolix)
- Per the NCCN prostate cancer guidelines the fine-particle formulation of abiraterone (Yonsa) can be used instead of the standard formulation (Zytiga) [Category 2B recommendation]

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen*	Maximum Dose
Abiraterone (Zytiga)	Castration-resistant prostate cancer	1,000 mg (four 250 mg tablets or two 500 mg tablets) PO QD in combination with prednisone 5 mg PO BID	1,000 mg QD; 1,000 mg BID if taking a strong CYP3A4 inducer
	Castration-naïve prostate cancer	1,000 mg (four 250 mg tablets or two 500 mg tablets) PO QD in combination with prednisone 5 mg PO QD	1,000 mg QD; 1,000 mg BID if taking a strong CYP3A4 inducer
Abiraterone (Yonsa)	Castration-resistant prostate cancer	500 mg (four 125 mg tablets) PO QD in combination with methylprednisolone 4 mg PO BID	500 mg QD; 500 mg BID if taking a strong CYP3A4 inducer

**Patients receiving Zytiga or Yonsa should also receive a GnRH analog concurrently or should have had bilateral orchiectomy.*

VI. Product Availability

Drug Name	Availability
Abiraterone (Zytiga)	Film-coated tablet: 500 mg Uncoated tablet: 250 mg (generic available as coated and uncoated)
Abiraterone (Yonsa)	Tablet: 125 mg

VII. References

1. Zytiga Prescribing Information. Horsham, PA: Janssen Biotech, Inc.; August 2021. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/202379s035lbl.pdf. Accessed October 4, 2023.
2. Yonsa Prescribing Information. Cranbury, NU: Sun Pharmaceutical Industries, Inc.; March 2022. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/210308s003lbl.pdf. Accessed October 4, 2023.
3. Abiraterone acetate. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.NCCN.org. Accessed October 10, 2023.
4. National Comprehensive Cancer Network. Prostate Cancer Version 04.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf. Accessed October 10, 2023.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2019 annual review: no significant changes; references reviewed and updated.	03.06.19	05.19
1Q 2020 annual review: modified to require that a GnRH analog should always be prescribed concurrently with abiraterone unless member has had a bilateral orchiectomy (regardless of CRPC or CSPC) per FDA labeling and NCCN guidelines; references reviewed and updated.	10.07.19	02.20
Added criterion for medical justification supporting inability to use generic abiraterone for brand Zytiga request.	07.23.20	
1Q 2021 annual review: no significant changes; updated *Appendix D* based on NCCN Prostate Cancer Version 02.2020; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	10.12.20	02.21
1Q 2022 annual review: no significant changes; added legacy WCG initial approval duration (WCG.CP.PHAR.84 to be retired); references reviewed and updated.	11.16.21	02.22
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less	01.20.22	05.22
Template changes applied to other diagnoses/indications.	10.12.22	
1Q 2023 annual review: added NCCN off-label use for non-metastatic prostate cancer with prostate-specific antigen (PSA) persistence or recurrence after radical prostatectomy and life expectancy > 5 years; added per NCCN compendium allowance for Yonsa use in combination with dexamethasone; consolidated legacy WellCare approval durations; references reviewed and updated.	09.19.22	02.23
1Q 2024 annual review: added requirement per NCCN if prescribed concurrently with Lynparza or Zejula, request is for metastatic	10.04.23	02.24

Reviews, Revisions, and Approvals	Date	P&T Approval Date
castration-resistant prostate cancer; removed abiraterone from Appendix B as dosing information is already included in Section V; references reviewed and updated.		

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.

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.