DRUG QUANTITY MANAGEMENT POLICY – PER RX

POLICY: Oncology – Lapatinib Drug Quantity Management Policy – Per Rx
- Tykerb® (lapatinib tablets – Novartis, generic)

REVIEW DATE: 05/02/2025

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Lapatinib, a tyrosine kinase inhibitor, is indicated for the following uses:[1]

- **Breast cancer**, in combination with capecitabine tablets for the treatment of patients with **advanced or metastatic disease** whose tumors overexpress human epidermal growth factor receptor 2 (HER2) and have received prior therapy including an anthracycline, a taxane, and trastuzumab.
  Limitation of Use: Patients should have disease progression on trastuzumab prior to initiation of treatment with lapatinib in combination with capecitabine tablets.
- **Breast cancer**, in combination with letrozole tablets for the treatment of postmenopausal women with **hormone receptor-positive metastatic disease** that overexpresses HER2 for whom hormonal therapy is indicated. Lapatinib in combination with an aromatase inhibitor has not been compared

to a trastuzumab-containing chemotherapy regimen for the treatment of metastatic breast cancer.

Lapatinib is discussed in guidelines from National Comprehensive Cancer Network for breast cancer (including breast cancer with CNS metastases), ependymoma, bone cancer, and colon or rectal cancer.[2-7]

Dosing

HER2-Positive Metastatic Breast Cancer

The recommended dose is 1,250 mg (5 x 250 mg tablets) given orally once daily (QD) on Days 1 to 21 continuously (105 tablets/21 days) in combination with capecitabine 2,000 mg/m^2/day on Days 1 to 14 in a repeating 21-day cycle.[1]

Hormone Receptor-Positive, HER2-Positive Metastatic Breast Cancer

The recommended dose is 1,500 mg (6 x 250 mg tablets) given orally QD continuously in combination with letrozole.[1]

Off-Label Dosing

Lapatinib has also be used for epidermal growth factor receptor (EGFR)-positive recurrent chordoma (bone cancer) at a dose of 1,500 QD.[2,3,8] Lapatinib has been used in colon and rectal cancers at a dose of 1,000 mg QD in combination with trastuzumab.[5,7]

Dose Modifications

Dose modifications for lapatinib are provided for breast cancer dosing.[1] The dose of lapatinib may need to be increased if a patient must take a strong cytochrome P450(CYP)3A4 inducer (e.g., dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, phenobarbital, St. John's wort). The dose of lapatinib should be titrated gradually from 1,250 mg/day up to 4,500 mg/day (HER2-positive metastatic breast cancer indication) or from 1,500 mg/day up to 5,500 mg/day (hormone receptor-positive, HER2-positive breast cancer indication) based on tolerability. If the strong inducer is discontinued, the lapatinib dose should be reduced to the indicated dose. The dose may require reduction for cardiac and other toxicities, severe hepatic impairment, diarrhea, and concomitant use with CYP3A4 inhibitors.[1]

Availability

Lapatinib (Tykerb, generic) is available as 250 mg tablets in bottles of 150 tablets.[1]

POLICY STATEMENT

This Drug Quantity Management program has been developed manage potential dose escalation and to provide a sufficient quantity of lapatinib. If the Drug Quantity Management rule is not met for the requested medication at the point of service, coverage will be determined by the Criteria below. All approvals are provided for 1 year in duration.

Drug Quantity Limits

Product	Strength and Form	Retail Maximum Quantity per Rx	Home Delivery Maximum Quantity per Rx
Tykerb® (lapatinib tablets, generic)	250 mg tablets	180 tablets	540 tablets

EXCEPTIONS TO THE QUANTITY LIMITS LISTED ABOVE ARE COVERED AS MEDICALLY NECESSARY WHEN THE FOLLOWING CRITERIA ARE MET. ANY OTHER EXCEPTION IS CONSIDERED NOT MEDICALLY NECESSARY.

CRITERIA

1. If the patient is taking a strong cytochrome P450 (CYP)3A4 inducer, approve 660 tablets per dispensing at retail or 1,980 tablets per dispensing at home delivery.
Note: Examples of strong CYP3A4 inducers are dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, phenobarbital, St. John's wort; this is not an all-inclusive list.

REFERENCES

1. Tykerb® tablets [prescribing information]. East Hanover, NJ: Novartis; January 2025.
2. The NCCN Bone Cancer Clinical Practice Guidelines in Oncology (Version 2.2025 – February 28, 2025). © 2025 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed on April 17, 2025.
3. The NCCN Drugs & Biologics Compendium. © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 17, 2025. Search terms: lapatinib.
4. The NCCN Central Nervous System Cancers Clinical Practice Guidelines in Oncology (version 5.2024 – March 18, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 17, 2025.
5. The NCCN Colon Cancer Clinical Practice Guidelines in Oncology (version 2.2025 – Mach 31, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 17, 2025.
6. The NCCN Breast Cancer Clinical Practice Guidelines in Oncology (version 4.2025 – April 17, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 17, 2025.
7. The NCCN Rectal Cancer Clinical Practice Guidelines in Oncology (version 2.2025 – March 31, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 17, 2025.
8. Stacchiotti S, Tamborini E, Lo Vullo S, et al. Phase II study on lapatinib in advanced EGFR-positive chordoma. *Ann Oncol*. 2013;24:1931-1936.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	Approval duration changed from 3 years to 1 year. Policy was updated to reflect the existing quantity limits when a product is obtained via home delivery.	05/24/2023

Annual Revision	No criteria changes.	05/29/2024
Annual Revision	No criteria changes.	05/02/2025

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