PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Gilotrif Prior Authorization Policy
- Gilotrif® (afatinib tablets – Boehringer Ingelheim)

REVIEW DATE: 12/11/2024

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 AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. 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

Gilotrif, a tyrosine kinase inhibitor (TKI), is indicated for the following uses:[1]

- **Non-small cell lung cancer (NSCLC)**, first-line treatment of patients with metastatic disease whose tumors have non-resistant epidermal growth factor receptor (*EGFR*) mutations as detected by an FDA-approved test.
  Limitations of use: The safety and efficacy of Gilotrif have not been established in patients whose tumors have resistant *EGFR* mutations.
- **NSCLC, squamous cell,** for the treatment of patients with metastatic disease progressing after platinum-based chemotherapy.

Guidelines

Gilotrif has been addressed in National Comprehensive Cancer Network (NCCN) guidelines.[2-4]

- **Head and Neck Cancer:** Guidelines (version 1.2025 – November 26, 2024) recommend Gilotrif as a single agent for the treatment of recurrent, unresectable, or metastatic non-nasopharyngeal cancers (lip, oral cavity, oropharynx, hypopharynx, glottis, larynx, supraglottic, larynx, ethmoid sinus, maxillary sinus, occult primary) in patients with disease progression or after platinum-based therapy (category 2B).[3]

- **Non-Small Cell Lung Cancer (NSCLC)**: Guidelines (version 11.2024 – October 15, 2024) recommend testing for sensitizing *EGFR* mutations in patients with metastatic disease.[4] Patients with sensitizing *EGFR* mutations have a significantly better response to the *EGFR* TKIs (erlotinib, Gilotrif, Iressa®, Tagrisso®, and Vizimpro). The most common *EGFR* mutations are exon 19 deletions and exon 21 (L858R) substitution mutations. Other less common mutations that are also sensitive to *EGFR* TKIs include L861Q, G719X, and S768I; these mutations cumulatively account for approximately 10% of all *EGFR* mutations. NCCN recommends the *EGFR* TKIs as first-line treatment for patients with advanced or metastatic NSCLC with *EGFR* exon 19 deletions, exon 21 (L858R) substitution mutations, S768I, L861Q, G719X, and S768I. Gilotrif is a category 1 recommendation under "Useful in Certain Circumstances" for *EGFR* exon 19 deletions and exon 21 substitutions. It is a "Preferred" first-line therapy (category 2A) for *EGFR* S768I, L861Q, and/or G719X mutations. NCCN does not recommend Gilotrif monotherapy for use as second-line treatment for patients with squamous cell NSCLC (without *EGFR* mutations); Gilotrif + Erbitux® (cetuximab injection) may be considered in patients with disease progression on *EGFR* TKI therapy. Gilotrif is not recommended in the guidelines for squamous cell NSCLC. However, it remains FDA-approved for this indication.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Gilotrif. All approvals are provided for the duration noted below.

- **Gilotrif® (afatinib tablets – Boehringer Ingelheim)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indications

1. **Non-Small Cell Lung Cancer – Epidermal Growth Factor Receptor (*EGFR*) Mutation-Positive.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has advanced or metastatic disease; AND
   C) Patient has sensitizing *EGFR* mutation-positive non-small cell lung cancer as detected by an approved test.
   Note: Examples of sensitizing *EGFR* mutation-positive non-small cell lung cancer include the following: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X, and S768I.

2. **Non-Small Cell Lung Cancer – Squamous Cell Carcinoma.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   A) Patient is ≥ 18 years of age; AND

B) Patient has metastatic squamous cell carcinoma; AND
C) Patient has disease progression after treatment with platinum-based chemotherapy.

Other Uses with Supportive Evidence

3. Head and Neck Cancer. Approve for 1 year if the patient meets ALL of the following (A, B, and C):
A) Patient is ≥ 18 years of age; AND
B) Patient has non-nasopharyngeal head and neck cancer; AND
Note: Examples of non-nasopharyngeal head and neck cancer are lip, oral cavity, oropharynx, hypopharynx, glottis, larynx, supraglottic larynx, ethmoid sinus, maxillary sinus, and occult primary.
C) Patient has disease progression on or after platinum-based chemotherapy.

CONDITIONS NOT COVERED

- **Gilotrif® (afatinib tablets – Boehringer Ingelheim)**

is(are) considered experimental, investigational or unproven for ANY other use(s); criteria will be updated as new published data are available.

REFERENCES

1. Gilotrif™ tablets [prescribing information]. Ridgefield, CT: Boehringer Ingelheim; April 2022.
2. The NCCN Drugs & Biologics Compendium. © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on December 6, 2024. Search terms: afatinib.
3. The NCCN Head and Neck Cancer Clinical Practice Guidelines in Oncology (version 1.2025 – November 26, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on December 6, 2024.
4. The NCCN Non-Small Cell Lung Cancer Clinical Practice Guidelines in Oncology (version 11.2024 – October 15, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on December 6, 2024.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes	11/29/2023
Annual Revision	No criteria changes.	12/11/2024