PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Ibrance Prior Authorization Policy
- Ibrance® (palbociclib capsules and tablets – Pfizer)

REVIEW DATE: 02/26/2025

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 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

Ibrance, a cyclin-dependent kinase (CDK) 4/6 inhibitor, is indicated for the treatment of hormone receptor positive (HR+), human epidermal growth factor receptor 2 (HER2)-negative **advanced or metastatic breast cancer** in adults, in combination with:[1]

- An aromatase inhibitor (AI) as initial endocrine-based therapy.
- Fulvestrant in patients with disease progression following endocrine therapy.

Guidelines

Ibrance is discussed in in guidelines from the National Comprehensive Cancer Network (NCCN):

- **Breast Cancer:** NCCN guidelines (version 1.2025 – January 31, 2025) recommend Ibrance + AI or fulvestrant (category 2A) as a first-line "Preferred Regimen" for recurrent unresectable (local or regional) or Stage IV HR+ and HER2-negative disease.[2,3] CDK4/6 inhibitor + fulvestrant is recommended for second- and subsequent-line therapy as a "Preferred Regimen", if CDK4/6 inhibitor was not previously used (category 1). However, the guidelines state in a footnote that if there is disease progression on Ibrance, there are limited phase II data to support the use of Kisqali® (ribociclib tablets) in the second-line setting.[2,3] The guidelines state

that in Phase III randomized controlled trials, fulvestrant in combination with a CDK4/6 inhibitor has shown overall survival benefit in the second-line setting. Ibrance is also recommended as first-line therapy in combination with Itovebi® (inavolisib tablet) and fulvestrant for phosphatidylinositol-3-kinase (*PIK3CA*) activating mutation after disease progression on adjuvant endocrine therapy or early disease relapse within 12 months of adjuvant endocrine therapy completion as "useful in certain circumstances" (category 1). The recommendations above are for postmenopausal women or premenopausal patient receiving ovarian ablation or suppression. The compendium recommends that men with breast cancer be treated similarly to postmenopausal women, except that the use of an AI is ineffective without concomitant suppression of testicular steroidogenesis.[3]

- **Liposarcoma:** NCCN guidelines on soft tissue sarcoma (version 4.2024 – November 21, 2024) recommend Ibrance as single-agent therapy for the treatment of unresectable retroperitoneal well-differentiated or dedifferentiated liposarcoma as "useful in certain circumstances" (category 2A).[4]

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Ibrance. All approvals are provided for the duration noted below. In the clinical criteria, as appropriate, an asterisk (*) is noted next to the specified gender. In this context, the specified gender is defined as follows: a woman is defined as an individual with the biological traits of a woman, regardless of the individual's gender identity or gender expression; men are defined as individuals with the biological traits of a man, regardless of the individual's gender identity or gender expression.

- **Ibrance® (palbociclib capsules and tablets - Pfizer)**

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. **Breast Cancer in a Woman***. Approve for 1 year if the patient meets ALL of the following (A, B, C, D, E, and F):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has recurrent or metastatic disease; AND
   - **C)** Patient has hormone receptor positive (HR+) [i.e., estrogen receptor positive {ER+} and/or progesterone receptor positive {PR+}] disease; AND
   - **D)** Patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer; AND
   - **E)** Patient meets ONE of the following (i or ii):
     - **i.** Patient is postmenopausal; OR

ii. Patient is pre/perimenopausal and meets ONE of the following (a or b):
a) Patient is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist; OR
Note: Examples of a GnRH agonist include leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous injection).
b) Patient has had surgical bilateral oophorectomy or ovarian irradiation; AND

F) Patient meets ONE of the following (i or ii):
i. Ibrance will be used in combination with anastrozole, exemestane, or letrozole; OR
ii. Ibrance will be used in combination with fulvestrant.

***** Refer to the Policy Statement.

2. Breast Cancer in a Man*. Approve for 1 year if the patient meets ALL of the following (A, B, C, D, and E):
A) Patient is ≥ 18 years of age; AND
B) Patient has recurrent or metastatic disease; AND
C) Patient has hormone receptor positive (HR+) [i.e., estrogen receptor positive {ER+} and/or progesterone receptor positive {PR+}] disease; AND
D) Patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer; AND
E) Patient meets ONE of the following (i or ii):
i. Patient meets BOTH of the following (a and b):
a) Patient is receiving a gonadotropin-releasing hormone (GnRH) analog; AND
Note: Examples of a GnRH analog include leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), Firmagon (degarelix acetate subcutaneous injection), Orgovyx (relugolix tablet).
b) Ibrance will be used in combination with anastrozole, exemestane, or letrozole; OR
ii. Ibrance will be used in combination with fulvestrant.

***** Refer to the Policy Statement.

Other Uses with Supportive Evidence

3. Liposarcoma. Approve for 1 year if the patient meets BOTH of the following (A and B):
A) Patient is ≥ 18 years of age; AND
B) Patient has well-differentiated/dedifferentiated liposarcoma.

CONDITIONS NOT COVERED

- **Ibrance® (palbociclib capsules and tablets - Pfizer)**

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

REFERENCES

1. Ibrance® capsules and tablets [prescribing information]. New York, NY: Pfizer Labs; December 2024.
2. The NCCN Breast Cancer Clinical Practice Guidelines in Oncology (version 1.2025 – January 31, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on February 21, 2025.
3. The NCCN Drugs & Biologics Compendium. © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on February 21, 2025. Search terms: palbociclib.
4. The NCCN Soft Tissue Sarcoma Clinical Practice Guidelines in Oncology (version 4.2024 – November 21, 2024) © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on February 24, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	02/22/2023
Annual Revision	No criteria changes.	02/21/2024
Annual Revision	No criteria changes.	02/26/2025