PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Oral – Kirsten RAt Sarcoma Virus Inhibitor) – Lumakras Prior Authorization Policy
- Lumakras™ (sotorasib tablets – Amgen)

REVIEW DATE: 05/14/2025

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

Lumakras, a Kirsten RAt Sarcoma (KRAS) inhibitor, is indicated for the following uses:[1]
- **Non-small cell lung cancer (NSCLC)**, treatment of *KRAS G12C*-mutated locally advanced or metastatic NSCLC, as determined by an FDA-approved test, in adults who have received at least one prior systemic therapy.
- **Colorectal cancer**, in combination with Vectibix® (panitumumab intravenous infusion) for the treatment of *KRAS G12C*-mutated metastatic colorectal cancer, as determined by an FDA-approved test, in adults who have received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy.

The NSCLC indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

Mutations in the *KRAS* gene most commonly occur at codon 12.[2] Data suggest that approximately 25% of patients with adenocarcinomas in a North American population have *KRAS* mutations. The prognosis of survival of patients with tumors with *KRAS* mutation is poorer compared with that of patients with tumors without *KRAS* mutation.

Guidelines
National Comprehensive Cancer Network (NCCN) guidelines recommend Lumakras in multiple conditions:

- **Ampullary Adenocarcinoma:** NCCN guidelines (version 2.2025 – January 10, 2025) recommend Lumakras as an option for disease progression after first line therapy in *KRAS G12C* mutation-positive tumors (category 2A).[4]
- **Colon and Rectal Cancer:** Guidelines for colon cancer (version 3.2025 – April 24, 2025) and rectal cancer (version 2.2025 – March 31, 2025) recommend Lumakras for some situations in patients with *KRAS G12C*-mutated disease.[5,6] For initial treatment in combination with Erbitux® (cetuximab intravenous infusion) or Vectibix® (panitumumab intravenous infusion) after previous FOLFOX (5-FU, leucovorin, and oxaliplatin) or CapeOX (capecitabine and oxaliplatin) within past 12 months or as monotherapy if patient is unable to tolerate Erbitux or Vectibix due to toxicity (category 2A). Lumakras is also recommended as subsequent therapy after previous chemotherapy [category 2A].
- **Non-Small Cell Lung Cancer:** NCCN guidelines (version 3.2025 – January 14, 2025) recommend Lumakras as a subsequent therapy for patients with metastatic NSCLC with the *KRAS G12C* mutation (category 2A) who have been previously treated with combination chemotherapy regimens (± immunotherapy).[2] Lumakras is a category 2B recommended therapy for brain metastases due to *KRAS G12C* mutation-positive NSCLC as per the NCCN Central Nervous System Cancers guidelines (version 5.2024 – March 18, 2025). Krazati™ (adagrasib tablets) is a category 2A recommended therapy in this setting.
- **Pancreatic Adenocarcinoma:** NCCN guidelines (version 2.2025 – February 3, 2025) recommend Lumakras as a subsequent therapy (category 2A) under "useful in certain circumstances" for locally advanced or metastatic disease. It is also recommended therapy for local recurrence in the pancreatic operative bed after resection (category 2A).[3]
- **Small Bowel Adenocarcinoma:** Guidelines (version 3.2025 – March 31, 2025) recommend Krazati as a second line and subsequent therapy (if not previously given) for *KRAS G12C* mutation-positive disease (category 2A).[7]

POLICY STATEMENT

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

- **Lumakras™ (sotorasib tablets - Amgen)**

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 (NSCLC).** 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 *KRAS G12C*-mutated locally advanced or metastatic NSCLC, as determined by an approved test; AND

C) Patient has been previously treated with at least one systemic regimen.
Note: Examples of systemic regimens include those containing one or more of the following products: Keytruda (pembrolizumab intravenous infusion), Opdivo (nivolumab intravenous infusion), Tecentriq (atezolizumab intravenous infusion), Alimta (pemetrexed intravenous infusion), Yervoy (ipilimumab intravenous infusion), Abraxane (albumin-bound paclitaxel intravenous infusion), bevacizumab, cisplatin, carboplatin, docetaxel, gemcitabine, paclitaxel, vinorelbine.

2. Colon or Rectal Cancer. 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 advanced or metastatic disease; AND

C) Patient has *KRAS G12C* mutation-positive disease; AND

D) Patient meets ONE of the following (i or ii):

i. The medication is used in combination with Erbitux (cetuximab intravenous infusion) or Vectibix (panitumumab intravenous infusion); OR

ii. As per the prescriber, the patient is unable to tolerate combination therapy; AND

E) Patient has previously received a chemotherapy regimen for colon or rectal cancer.
Note: Examples of chemotherapy regimens include a fluoropyrimidine such as 5-fluorouracil (5-FU), capecitabine; oxaliplatin, irinotecan, or an adjunctive chemotherapy regimen such as FOLFOX (5-FU, leucovorin, and oxaliplatin) or CapeOX (capecitabine and oxaliplatin).

Other Uses with Supportive Evidence

3. Ampullary Adenocarcinoma. 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 *KRAS G12C*-mutated disease, as determined by an approved test; AND

C) The medication is used as subsequent therapy.

4. Pancreatic Adenocarcinoma. 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 *KRAS G12C*-mutated disease, as determined by an approved test; AND

C) Patient meets ONE of the following (i or ii):

i. Patient meets BOTH of the following (a and b):

a) Patient has locally advanced or metastatic disease; AND

b) Patient has been previously treated with at least one systemic regimen; OR
Note: Examples of systemic regimens include one or more of the following: gemcitabine, albumin-bound paclitaxel, capecitabine, Keytruda (pembrolizumab intravenous infusion), FOLFIRINOX (5-fluoruracil + leucovorin + irinotecan + oxaliplatin).

ii. Patient has recurrent disease after resection.

5. Small Bowel Adenocarcinoma. Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):

A) Patient is ≥ 18 years of age; AND

B) Patient has advanced or metastatic disease; AND

C) Patient has *KRAS G12C* mutation-positive disease; AND

D) The medication will be used as subsequent therapy.

CONDITIONS NOT COVERED

- **Lumakras™ (sotorasib tablets - Amgen)**

is(are) considered not medically necessary for ANY other use(s).

REFERENCES

1. Lumakras™ tablets [prescribing information]. Thousand Oaks, CA: Amgen; January 2025.
2. The NCCN Non-Small Cell Lung Cancer Clinical Practice Guidelines in Oncology (version 3.2025 – January 14, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on May 12, 2025.
3. The NCCN Pancreatic Adenocarcinoma Clinical Practice Guidelines in Oncology (version 2.2025 – February 3, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on May 12, 2025.
4. The NCCN Ampullary Adenocarcinoma Clinical Practice Guidelines in Oncology (version 2.2025 – January 10, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on May 12, 2025.
5. The NCCN Colon Cancer Clinical Practice Guidelines in Oncology (version 3.2025 – April 24, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org/. Accessed on May 12, 2025.
6. 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 May 12, 2025.
7. The NCCN Small Bowel Adenocarcinoma Clinical Practice Guidelines in Oncology (version 3.2025 – March 31, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org/. Accessed on May 12, 2025.
8. The NCCN Drugs and Biologics Compendium. © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on May 12, 2025. Search term: sotorasib.
9. 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 May 9, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Pancreatic Adenocarcinoma:** Added new condition of approval and criteria based on guideline recommendations**.**	06/14/2023
Annual Revision	**Ampullary Adenocarcinoma:** Added new condition of approval and criteria based on guidelines. **Colon or Rectal Cancer:** Added new condition of approval and criteria based on guidelines.	06/26/2024
Selected Revision	**Colon or Rectal Cancer:** Moved this indication from Other Uses with Supportive Evidence to FDA-Approved Indication. Deleted "unresectable" disease qualifier. For criterion referring to combination regimen, deleted Note with examples and instead specified within criteria "…used in combination with Erbitux (cetuximab intravenous infusion) or Vectibix (panitumumab intravenous infusion)."	01/29/2025

Update	04/20/2025: The policy name was changed from "Oncology – Lumakras PA Policy" to "Oncology (Oral – Kirsten RAt Sarcoma Virus Inhibitor) – Lumakras PA Policy".	N/A
Annual Revision	**Small Bowel Adenocarcinoma:** Under "Other Uses with Supportive Evidence" added new condition of approval and criteria.	05/14/2025

N/A – Not applicable.