Clinical Policy: Cobimetinib (Cotellic)

Reference Number: CP.PHAR.380
Effective Date: 11.16.16
Last Review Date: 05.23
Line of Business: Commercial, HIM, Medicaid

Revision Log

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

Description

Cobimetinib (Cotellic®) is a kinase inhibitor.

FDA Approved Indication(s)

Cotellic is indicated:

- For the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, in combination with vemurafenib.
- As a single agent for the treatment of adult patients with histiocytic neoplasms

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 Cotellic is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Melanoma (must meet all)**:**

1. Diagnosis of melanoma with BRAF V600E or V600K mutation;
2. Disease is for treatment of one of the following (a, b, or c):
   a. Unresectable or metastatic melanoma;
   b. Stage III melanoma as adjuvant therapy;
   c. Limited resectable melanoma;
3. Prescribed by or in consultation with an oncologist;
4. Age ≥ 18 years;
5. Prescribed in combination with Zelboraf®;*
   **Prior authorization may be required.*
6. Member has unacceptable toxicities to Tafinlar®/Mekinist®, or Tafinlar/Mekinist are not appropriate for the member on the basis of agent side-effect profiles;
7. For Cotellic requests, member must use cobimetinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
8. Request meets one of the following (a or b):*
   a. Dose does not exceed both of the following (i and ii) for the first 21 days of each 28-day cycle:
      i. 60 mg per day;
      ii. 3 tablets per day;

b. 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. Histiocytic Neoplasms (must meet all)**:**

1. Diagnosis of one of the following histiocytic neoplasms (a, b, c, d, or e):
   a. Langerhans cell histiocytosis (LCH);
   b. Rosai-Dorfman disease;
   c. Erdheim-Chester disease (ECD)
   d. Xanthogranuloma
   e. Mixed histiocytosis;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Prescribed as a single agent;
5. Disease is characterized as one of the following (a, b, or c):
   a. Multi-system;
   b. Recurrent or refractory;
   c. Single system and unlikely to benefit from conventional therapies;
6. If disease is positive for a BRAF mutation, member has documentation of one of the following (a or b):
   a. BRAF V600E mutation, and unable to access a BRAF inhibitor or prior treatment with a BRAF inhibitor has been discontinued due to intolerable side effects or toxicity;
   b. BRAF-mutated ECD or LCH, and disease has progressed on BRAF inhibitor therapy;
7. For Cotellic requests, member must use cobimetinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
8. Request meets one of the following (a or b):*
   a. Dose does not exceed both of the following (i and ii) for the first 21 days of each 28-day cycle:
      i. 60 mg per day;
      ii. 3 tablets per day;
   b. 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

C. Central Nervous System Cancers (off-label) (must meet all)**:**

1. Diagnosis of one of the following (a, b, c, or d):
   a. Adult low-grade glioma (World Health Organization [WHO] grade 1);
   b. Recurrent WHO Grade 2 or 3 adult oligodendroglioma (IDH-mutant, 1p19q codeleted);

c. Recurrent adult IDH-mutant astrocytoma (WHO grade 2, 3, or 4);
d. Glioblastoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is positive for the BRAF V600E mutation;
5. Prescribed in combination with Zelboraf;*
**Prior authorization may be required.*
6. For Cotellic requests, member must use cobimetinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
7. Request meets one of the following (a or b):*
a. Dose does not exceed both of the following (I and ii) for the first 21 days of each 28-day cycle:
i. 60 mg per day;
ii. 3 tablets per day;
b. 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

D. Other diagnoses/indications
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. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Cotellic for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Cotellic requests, member must use cobimetinib, if available, unless contraindicated or clinically significant adverse effects are experienced;

4. Request meets one of the following (a or b):*
   a. Dose does not exceed both of the following (I and ii) for the first 21 days of each 28-day cycle:
      i. 60 mg per day;
      ii. 3 tablets per day;
   b. 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;

B. Treatment of melanoma in patients with wild type BRAF gene.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

BRAF: B-Raf proto-oncogene serine/threonine kinase
ECD: Erdheim-Chester disease
FDA: Food and Drug Administration
LCH: Langerhans cell histiocytosis
WHO: World Health Organization

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Melanoma, histiocytic neoplasms	60 mg (three tablets) PO QD for 21 days, then off for 7 days (28-day cycle)	60 mg/day

VI. Product Availability

Tablet: 20 mg

VII. References

1. Cotellic Prescribing Information. South San Francisco, CA: Genentech; October 2022. Available at: https://www.gene.com/download/pdf/cotellic_prescribing.pdf. Accessed January 26, 2023.
2. National Comprehensive Cancer Network Histiocytic Neoplasms Version 1.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/histiocytic_neoplasms.pdf. Accessed January 26, 2023.
3. Zelboraf Prescribing Information. South San Francisco, CA: Genentech USA, Inc.; May 2020. Available at: https://www.gene.com/download/pdf/zelboraf_prescribing.pdf. Accessed January 26, 2023.
4. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed January 26, 2023.
5. National Comprehensive Cancer Network. Central Nervous System Cancers Version 2.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf. Accessed January 26, 2023.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2019 annual review: no significant changes; references reviewed and updated.	02.26.19	05.19
2Q 2020 annual review: added HIM line of business; revised continuation approval duration from 6 to 12 months; for dosing limits in Section I and II clarified dosing is limited to the first 21 days of each 28-day cycle; references reviewed and updated.	02.10.20	05.20
2Q 2021 annual review: oral oncology generic redirection language added; revised reference to HIM off-label use policy from HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	01.14.21	05.21
2Q 2022 annual review: added NCCN-supported indications criteria for histiocytic neoplasms and central nervous system cancers; Commercial approval durations revised from "Length of Benefit" to "12 months or duration of request, whichever is less"; references reviewed and updated.	02.11.22	05.22
Template changes applied to other diagnoses/indications.	09.22.22	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
RT4: off-label criteria for histiocytic neoplasms converted to FDA approved use and updated per label, clinical trial, and NCCN.	01.17.23	
2Q 2023 annual review: for Melanoma criteria, added stage III melanoma as adjuvant therapy, limited resectable melanoma, and requirements for trial of Tafinlar/Mekinist, updated off-label criteria for CNS cancers to include WHO grade 2, or 3 adult oligodendroglioma and WHO grade 2, 3, or 4 adult IDH-mutant astrocytoma, per NCCN-supported 2A recommendation; removed anaplastic glioma and grade 2 glioma as terminology is no longer used in NCCN compendium; references reviewed and updated.	02.15.23	05.23

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.