Reference number(s)
1679-A

SPECIALTY GUIDELINE MANAGEMENT

CYRAMZA (ramucirumab)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications
1. Gastric Cancer: Cyramza as a single agent, or in combination with paclitaxel, is indicated for the treatment of patients with advanced or metastatic, gastric or gastro-esophageal junction (GEJ) adenocarcinoma with disease progression on or after prior fluoropyrimidine-or platinum-containing chemotherapy.
2. Non-Small Cell Lung Cancer (NSCLC): Cyramza, in combination with docetaxel, is indicated for the treatment of patients with metastatic NSCLC with disease progression on or after platinum-based chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving Cyramza.
3. Colorectal Cancer: Cyramza, in combination with FOLFIRI (irinotecan, folinic acid, and 5-fluorouracil), is indicated for the treatment of patients with metastatic colorectal cancer with disease progression on or after prior therapy with bevacizumab, oxaliplatin, and a fluoropyrimidine.

B. Compendial Uses
1. Esophageal adenocarcinoma
2. Colorectal cancer, advanced
3. Hepatobiliary cancer

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Gastric, Gastro-esophageal Junction (GEJ), and Esophageal Adenocarcinoma
Authorization of 12 months may be granted for treatment of gastric, gastro-esophageal junction (GEJ), and esophageal adenocarcinoma.

B. Non-Small Cell Lung Cancer (NSCLC)
Authorization of 12 months may be granted for treatment of metastatic NSCLC.

C. Colorectal Cancer
Authorization of 12 months may be granted for treatment of advanced or metastatic colorectal cancer.

D. Hepatobiliary cancer
Authorization of 12 months may be granted for treatment of hepatobiliary cancer.

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III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Cyramza [package insert]. Indianapolis, IN: Eli Lilly and Company; November 2018.
2. The NCCN Drugs & Biologics Compendium® © 2019 National Comprehensive Cancer Network, Inc. Available at: https://www.nccn.org. Accessed January 28, 2019.
3. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology™ Gastric Cancer (Version 2.2018) https://www.nccn.org. Accessed January 28, 2019.
4. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology™ Esophageal and Esophagogastric Junction Cancers (Version 2.2018). https://www.nccn.org. Accessed January 28, 2019.
5. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology™ Non-Small Cell Lung Cancer (Version 3.2019). https://www.nccn.org. Accessed January 28, 2019.
6. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology™ Colon Cancer (Version 4.2018). https://www.nccn.org. Accessed January 28, 2019.
7. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology™ Rectal Cancer (Version 3.2018). https://www.nccn.org. Accessed January 28, 2019.
8. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology™ Hepatobiliary Cancers (Version 1.2019). https://www.nccn.org. Accessed January 28, 2019.

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