Clinical Policy Title:	everolimus
Policy Number:	RxA.008
Drug(s) Applied:	Afinitor®, Afinitor Disperz®, everolimus, Zortress®
Original Policy Date:	02/07/2020
Last Review Date:	08/27/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Breast Cancer (must meet all):

1. Diagnosis of recurrent or metastatic breast cancer;
2. Disease is HR-positive and HER2-negative;
3. Member is postmenopausal; or premenopausal receiving ovarian ablation or suppression;
4. Prior history of endocrine therapy unless contraindicated or clinically significant adverse effects are experienced;
5. Prescribed in combination with exemestane, fulvestrant or tamoxifen;
6. Request is for Afinitor® or Afinitor Disperz®.

Approval Duration

All Lines of Business (except Medicare): 6 months

B. Neuroendocrine Tumors (must meet all):

1. Diagnosis of NET of one of the following origins (a – e):
   a. Pancreatic;
   b. GI tract;
   c. Lung;
   d. Bronchopulmonary (off-label);
   e. Thymus (off-label);
2. Disease is unresectable, locally advanced or metastatic;
3. Request is for Afinitor® or Afinitor Disperz®.

Approval Duration

All Lines of Business (except Medicare): 6 months

C. Renal cell carcinoma (must meet all):

1. Diagnosis of relapsed or stage IV (unresectable or metastatic) RCC;
2. If clear cell histology, failure of a prior therapy (e.g. Inlyta®, Votrient®, Sutent®, Nexavar®) unless contraindicated or clinically significant adverse effects are experienced;
   *Prior authorization may be required for prior therapy
3. Request is for Afinitor® or Afinitor Disperz®.

Approval Duration

All Lines of Business (except Medicare): 6 months

D. Renal Angiomyolipoma with Tuberous Sclerosis Complex (must meet all):
1. Diagnosis of renal angiomyolipoma associated with TSC, not requiring immediate surgery;
2. Request is for Afinitor® or Afinitor Disperz®.

Approval Duration
All Lines of Business (except Medicare): 6 months

E. Tuberous Sclerosis Complex with Subependymal Giant Cell Astrocytoma (must meet all):
1. Diagnosis of SEGA associated with TSC;
2. Member is not a candidate for curative surgical resection;
3. Request is for Afinitor® or Afinitor Disperz®.

Approval duration
All Lines of Business (except Medicare): 6 months

F. Tuberous Sclerosis Complex-Associated Partial-Onset Seizures (must meet all):
1. Diagnosis of partial-onset seizures associated with TSC;
2. Request is for Afinitor Disperz®.

Approval duration
All Lines of Business (except Medicare): 6 months

G. Prophylaxis of Organ Rejection (must meet all):
1. Member has received or is scheduled for a kidney or liver transplant;
2. For kidney transplant, failure of tacrolimus unless contraindicated or clinically significant adverse effects are experienced;
3. Request is for Zortress®;
4. Prescribed in combination with one of the following (a or b):
   a. For kidney transplant: Simulect®, cyclosporine, and corticosteroids;
   b. For liver transplant: tacrolimus and corticosteroids.

Approval duration
All Lines of Business (except Medicare): 6 months

H. NCCN Compendium Indications (off-label) (must meet all):
1. Diagnosis of one of the following (a, b, c, d, e, f, g, h, I and j):
   a. Soft Tissue Sarcoma- PEComa, angiomyolipoma (recurrent), or lymphangioleiomyomatosis;
   b. Adult low-grade (WHO grade II) infiltrative supratentorial astrocytoma/oligodendroglioma;
   c. Classical Hodgkin lymphoma (HL); WM//LPL (single agent therapy as alternative therapy for previously treated disease that does not respond to primary therapy or for progressive or relapsed disease);
   d. Thyroid Carcinoma (HC, FC, PC), thymoma, or thymic carcinoma (refractory, recurrent, progressive or metastatic disease); Endometrial carcinoma (in combination with letrozole);
   e. Gastrointestinal stromal tumors (GIST) (therapy in combination with imatinib, Sutent®, or Stivarga® for disease progression after single agent therapy with imatinib, Sutent®, and Stivarga®)*;
   *Prior authorization may be required.
   f. DTC (i.e., follicular, Hurthle cell or papillary carcinoma): Failure of Lenvima® or Nexavar® unless contraindicated or clinically significant adverse effects are experienced;
   g. Histiocytic Neoplasms (Langerhans Cell Histiocytosis, Rosai-Dorfman Disease, a Erdheim-Chester Disease
   h. Uterine Neoplasms - Endometrial Carcinoma

i. Waldenström Macroglobulinemia / Lymphoplasmacytic Lymphoma - Waldenström Macroglobulinemia / Lymphoplasmacytic Lymphoma
*Prior authorization may be required.

2. Request is for Afinitor® or Afinitor Disperz®.

Approval duration

All Lines of Business (except Medicare): 6 months

II. Continued Therapy Approval

A. All Indications (must meet all):

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

Approval Duration

All Lines of Business (except Medicare): 12 months

References

1. National Comprehensive Cancer Network. Kidney Cancer Version 1.2025. Available at: http://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf . Accessed August 27, 2024.
2. National Comprehensive Cancer Network. Neuroendocrine and Adrenal Tumors Version 2.2024. Available at: http://www.nccn.org/professionals/physician_gls/pdf/neuroendocrine.pdf. Accessed August 27, 2024.
3. National Comprehensive Cancer Network. Breast Cancer Version 4.2024. Available at: http://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed August 27, 2024.
4. Kidney Disease Improving Global Outcomes. KDIGO clinical practice guideline for the care of kidney transplant recipients. American Journal of Transplantation 2009; 9 (Suppl 3): Si- S155. doi: 10.1111/j.1600-6143.2009. 02834.x. Available at: https://kdigo.org/wp-content/uploads/2017/02/KDIGO-2009-Transplant-Recipient-Guideline-English.pdf. Accessed August 27, 2024.
5. Bia M, Adey DB, Bloon RD, Chan L, Kulkarni S, and Tomlanovich S. KDOQI US Commentary on the 2009 KDIGO clinical practice guideline for the care of kidney transplant recipients. Am J Kidneys Dis 2010; 56:189-218. Available at: https://www.kidney.org/sites/default/files/docs/transplant_commentary2010_ajkd.pdf. Accessed August 27, 2024.
6. Lucey MR, Terrault N, Ojo L, et al. Long-term management of the successful adult liver transplant: 2012 practice guideline by the American Association for the Study of Liver Diseases and the American Society of Transplantation. Liver Transplantation 2013; 19:3-26. Available at: https://pubmed.ncbi.nlm.nih.gov/23281277/. Accessed August 27, 2024.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy was established	01/2020	02/07/2020
2Q2020 P&T Review; Updates below, references reviewed and updated 1. TSC association seizures – neurologist added; 2. meningioma removed NCCN 2B; 3. NET bronchopulmonary disease added NCCN 2A; 4. specified max dose requirement in continued therapy applies to all diagnoses except partial-onset seizures associated with TSC and organ rejection prophylaxis;	4/2020	05/20/2020

5. Breast cancer: Added additional criteria of postmenopausal; or premenopausal receiving ovarian ablation or suppression.		
Policy was reviewed. 1. Line of Business Policy Applies to was updated to “All lines of business”. 2. Initial therapy criteria I.H.1(a) & I.H.1(b) were added. 3. Continued therapy criteria II.A.1 was rephrased to “Currently receiving medication that has been authorized by Rxadvance…”. 4. References were reviewed and updated.	02/11/2021	03/09/2021
Policy was reviewed. 1. Initial Approval Criteria a. IE3: Updated to include new age criteria Age ≥ 1 years. b. IF2: Updated to include new age criteria Age ≥ 2 years 2. Initial Approval Criteria, IH1: Updated to include new indication a. Histiocytic Neoplasms (Langerhans Cell Histiocytosis, Rosai-Dorfman Disease, a Erdheim-Chester Disease b. Uterine Neoplasms - Endometrial Carcinoma c. Waldenström Macroglobulinemia / Lymphoplasmacytic Lymphoma - Waldenström Macroglobulinemia / Lymphoplasmacytic Lymphoma 3. References were reviewed and updated.	12/06/2021	01/17/2022
Policy was reviewed. 1. Continued Therapy Criteria II.A.3.a: Updated new dose does not exceed from 20 mg to 10 mg per day. 2. References were reviewed and updated.	07/04/2022	10/19/2022
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Added generic everolimus to Drug(s) Applied. 2. Removed age restrictions. 3. Removed prescriber restrictions. 4. Removed dose restrictions. 5. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days.	8/27/2024	9/13/2024

6. Removed reauthorization requirement for positive response to therapy. 7. Updated approval duration verbiage. 8. References were reviewed and updated.		