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Clinical Policy Title:	dacomitinib
Policy Number:	RxA.557
Drug(s) Applied:	Vizimpro®
Original Policy Date:	03/06/2020
Last Review Date:	8/28/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Non-Small Cell Lung Cancer (NSCLC) (must meet all):

1. Diagnosis of NSCLC;
2. Disease is recurrent, advanced or metastatic;
3. Disease is positive for EGFR mutation (e.g., exon 19 deletion or L858R).

Approval Duration

All Lines of Business (except Medicare): 6 months

II. Continued Therapy Approval

A. Non-Small Cell Lung Cancer (NSCLC) (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. Wu YL, Cheng Y, Zhou X, et al. Dacomitinib versus gefitinib as first-line treatment for patients with EGFR-mutation-positive non-small-cell lung cancer (ARCHER 1050): a randomized, open-label, phase 3 trial. Lancet Oncol 2017;18:1454-66. Available at: http://dx.doi.org/10.1016/S1470-2045(17)30608-3. Accessed August 28, 2024.
2. National Comprehensive Cancer Network. Non-Small Cell Lung Cancer Version 8.2024. Available at https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed August 28, 2024.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	03/06/2020
Policy was reviewed: 1. Clinical policy title updated 2. Line of business policy applies to was updated to All lines of business 3. Continued Therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance..."	09/22/2020	12/07/2020

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

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4. Reference reviewed and updated.		
Policy was reviewed: 1. Continued Therapy Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". 2. References were reviewed and updated.	10/03/2021	12/07/2021
Policy was reviewed: 1. References were reviewed and updated.	07/26/2022	10/19/2022
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Removed age restrictions. 2. Removed prescriber restrictions. 3. Removed dose restrictions. 4. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days. 5. Removed reauthorization requirement for positive response to therapy. 6. Updated approval duration verbiage 7. References were reviewed and updated.	8/28/2024	9/13/2024

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