Clinical Policy Title:	selpercatinib
Policy Number:	RxA.636
Drug(s) Applied:	Retevmo®
Original Policy Date:	09/14/2020
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 recurrent, advanced, or metastatic NSCLC;
2. Documentation of RET fusion-positive disease (e.g., KIF5B-RET);
3. Member has not received prior RET targeted therapy (e.g., Gavreto®);
4. Prescribed as a single agent.

Approval Duration

All Lines of Business (except Medicare): 12 months

B. Thyroid Cancer (must meet all):

1. Diagnosis of one of the following (a or b):
   a. RET- mutant medullary thyroid cancer (MTC);
   b. RET fusion-positive thyroid cancer;
2. Disease is recurrent, advanced, or metastatic;
3. For medullary thyroid cancer (MTC), disease requires treatment with systemic therapy;
4. For thyroid cancer, member meets one of the following (a or b):
   a. Disease has progressed on or following prior systemic treatment (e.g, chemotherapy);
   b. There are no satisfactory alternatives available;
5. Member has not received prior RET targeted therapy (e.g., Gavreto®);
6. Prescribed as a single agent.

Approval Duration

All Lines of Business (except Medicare): 12 months

C. RET Fusion-Positive Solid Tumors (must meet all):

1. Diagnosis of a locally advanced or metastatic solid tumor;
2. Documentation of RET fusion-positive disease;
3. One of the following (a or b):
   a. Disease has progressed on or following prior systemic treatment;
   b. Member has no satisfactory alternative treatment options;
4. Member has not received prior RET targeted therapy (e.g., Gavreto®);
5. Prescribed as a single agent.

Approval duration

All Lines of Business (except Medicare): 12 months or duration of request, whichever is less

D. Histiocytic Neoplasms - Langerhans Cell Histiocytosis (off -label) (must meet all):
1. Diagnosis of Langerhans Cell Histiocytosis;
2. Request is for first-line or subsequent therapy for RET fusion target for single agent.

Approval duration
All Lines of Business (except Medicare): 12 months

E. Histiocytic Neoplasms - Erdheim-Chester Disease (off -label) (must meet all):
1. Diagnosis of Erdheim-Chester Disease;
2. Request is for first-line or subsequent therapy for RET fusion target as a single agent.

Approval duration
All Lines of Business (except Medicare): 12 months

F. Histiocytic Neoplasms - Rosai-Dorfman Disease (off -label) (must meet all):
1. Diagnosis of Rosai-Dorfman Disease;
2. Request if for first-line or subsequent therapy for RET fusion target as a single agent.

Approval duration
All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. All Indications in Section I (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. Bongarzone I, et al. RET/NTRK1 Rearrangements in Thyroid Gland Tumors of the Papillary Carcinoma Family: Correlation with Clinicopathological Features. Available at: https://pubmed.ncbi.nlm.nih.gov/9516975/. Accessed August 28, 2024.
2. National Comprehensive Cancer Network Guidelines. Histiocytic Neoplasms. Version 2.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/histiocytic_neoplasms.pdf. Accessed August 28, 2024.
3. National Comprehensive Cancer Network Guidelines. Occult Primary. Version 1.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/occult.pdf. Accessed August 28, 2024.
4. National Comprehensive Cancer Network Guidelines. Neuroendocrine and Adrenal Tumors. Version 2.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/neuroendocrine.pdf. Accessed August 28, 2024.
5. National Comprehensive Cancer Network Guidelines. Cervical Cancer. Version 3.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cervical.pdf. Accessed August 28, 2024.
6. National Comprehensive Cancer Network Guidelines. Small Bowel Adenocarcinoma. Version 4.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/small_bowel.pdf. Accessed August 28, 2024.
7. National Comprehensive Cancer Network Guidelines. Head and Neck Cancers. Version 4.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/head-and-neck.pdf. Accessed August 28, 2024.
8. National Comprehensive Cancer Network Guidelines. Ovarian Cancer Continue Including Fallopian Tube Cancer and Primary Peritoneal Cancer. Version 3.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ovarian.pdf. Accessed August 28, 2024.
9. National Comprehensive Cancer Network Guidelines. Esophageal and Esophagogastric Junction Cancers. Version 4.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/esophageal.pdf. Accessed

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11. National Comprehensive Cancer Network Guidelines. Thyroid Carcinoma. Version 4.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf. Accessed August 28, 2024.
12. National Comprehensive Cancer Network Guidelines. Central Nervous System Cancers. Version 2.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf. Accessed August 28, 2024.
13. National Comprehensive Cancer Network Guidelines. Non-Small Cell Lung Cancer. Version 8.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed August 28, 2024.
14. National Comprehensive Cancer Network Guidelines. Breast Cancer. Version 4.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed August 28, 2024.
15. National Comprehensive Cancer Network Guidelines. Biliary Tract Cancer. Version 3.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/btc.pdf. Accessed August 28, 2024.
16. National Comprehensive Cancer Network Guidelines. Colon Cancer. Version 5.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf. Accessed August 28, 2024.
17. National Comprehensive Cancer Network Guidelines. Rectal Cancer. Version 4.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/rectal.pdf. Accessed August 28, 2024.
18. National Comprehensive Cancer Network Guidelines. Soft Tissue Sarcoma. Version 2.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/sarcoma.pdf. Accessed August 28, 2024.
19. National Comprehensive Cancer Network Guidelines. Ampullary Adenocarcinoma. Version 2.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ampullary.pdf. Accessed August 28, 2024.
20. National Comprehensive Cancer Network Guidelines. Pancreatic Adenocarcinoma. Version 3.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/pancreatic.pdf. Accessed August 28, 2024.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	07/07/2020	09/14/2020
Policy was reviewed: 1. Line of Business was updated from “Commercial, Medicaid” to “All line of Business”. 2. Initial Approval Criteria I.A.5.a was updated to include “240 mg per day for < 50 kg weight;”. 3. Initial Approval Criteria I.A.5.b was updated to include “320 mg per day for ≥ 50 kg weight;”. 4. Initial Approval Criteria I.B was updated to include off-label indication “Histiocytic Neoplasms - Langerhans Cell Histiocytosis (off -label)…”. 5. Initial Approval Criteria I.C was updated to include off-label indication “Histiocytic Neoplasms- Erdheim-Chester Disease (off -label)…”. 6. Initial Approval Criteria I.D was updated to include off-label indication “Histiocytic Neoplasms - Rosai-Dorfman Disease (off -label)…”. 7. Continued Therapy Approval Criteria II.A was updated from “Non-Small Cell Lung Cancer” to “Non-Small Cell Lung Cancer or Medullary Thyroid	07/06/2021	09/14/2021

Cancer and other off label indications (must meet all)…". 8. Continued Therapy Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". 9. Continued Therapy Criteria II.A.4.a was updated to include "240 mg per day for < 50 kg weight;". 10. Continued Therapy Criteria II.A.4.b was updated to include "320 mg per day for ≥ 50 kg weight;". 11. References were reviewed and updated.		
Policy was reviewed: 1. Initial approval criteria reviewed and updated. 2. References were reviewed and updated.	04/06/2022	07/18/2022
Policy was reviewed: 1. Initial Approval Criteria, I.A.5 and I.B.5: Updated to remove concurrent therapy criteria Retevmo® is not prescribed concurrently with Gavreto®. 2. Initial Approval Criteria, I.A.6 and I.B.11: Updated to remove prior generic Preffered criteria For brand Retevmo® requests, member must use generic selpercatinib, if available, unless contraindicated or clinically significant adverse effects are experienced. 3. Initial Approval Criteria, I.B.1.a: Updated diagnostic criteria from Medullary thyroid cancer (MTC) to RET- mutant medullary thyroid cancer (MTC). 4. Initial Approval Criteria, I.B.1.b: Updated to include new diagnosis criteria RET fusion-positive thyroid cancer. 5. Initial Approval Criteria, I.B.1.b and I.B.1.c: Updated to remove diagnostic criteria: a. Differentiated thyroid carcinoma (DTC; Hurthle cell, papillary, follicular); b. Anaplastic thyroid carcinoma (ATC to RET- mutant medullary thyroid cancer (MTC). 6. Initial Approval Criteria, I.B.5: Updated prior therapy criteria from For MTC, documentation of RET mutant-positive disease (e.g., RET M918T) to For Medullary thyroid cancer (MTC) :Disease requires treatment with systemic therapy. 7. Initial Approval Criteria, I.B.6: Updated prior therapy criteria from For DTC, oncocytic or ATC, documentation of RET fusion-positive disease (e.g., CCDC6-RET, KIF5B-RET), member is radioactive iodine-refractory (if radioactive iodine	05/08/2023	07/13/2023

is appropriate) to For Thyroid cancer: Member meets one of the following (a or b): a. Disease has progressed on or following prior systemic treatment (e.g, chemotherapy); b. There are no satisfactory alternatives available; 8. Initial Approval Criteria, I.C: Updated to include approval criteria for indication, RET Fusion-Positive Solid Tumors. 9. Initial Approval Criteria, I.D.3: Updated prior therapy criteria from If the request is for first-line or subsequent therapy for RET fusion target for single agent;, useful in certain circumstances, for (i, ii, iii, iv, or v): i. Multisystem Langerhans Cell Histiocytosis (LCH) with symptomatic or impending organ dysfunction; ii. Pulmonary LCH; iii. Multifocal single system bone disease not responsive to treatment with a bisphosphonate and >2 lesions (useful in certain circumstances); iv. CNS lesions; to Request is for first-line or subsequent therapy for RET fusion target for single agent; 10. Initial Approval Criteria, I.E.4: Updated to remove diagnostic criteria Request is for one of the following (a or b): a. Erdheim-Chester Disease (ECD) with symptomatic disease; b. Relapsed/refractory disease; 11. Initial Approval Criteria, I.F.4: Updated the prior therapy criteria from If the request if for first-line or subsequent therapy for RET fusion target as a single agent; (a, b or c): a. Symptomatic unresectable (bulky/site of disease) unifocal disease; b. Symptomatic multifocal disease; c. Relapsed/refractory disease; to Request if for first-line or subsequent therapy for RET fusion target as a single agent 12. Initial Approval Criteria, I.A, I.B, I.D, I.E, I.F: Updated Approval duration from 3 to 12 months for Commercial and Medicaid. 13. Continued Therapy Approval Criteria II.A.1 was rephrased to Member is currently receiving medication that has been authorized by		

RxAdvance or the member has met initial approval criteria listed in this policy. 14. Continued Therapy Approval Criteria, II.A: Updated Approval duration from 6 to 12 months for Commercial. 15. References were reviewed and updated.		
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 other reauthorization requirements including positive response to therapy. 6. Updated approval duration verbiage. 7. References were reviewed and updated.	8/28/2024	9/13/2024