# PRIOR AUTHORIZATION POLICY

**POLICY:** Oncology (Injectable) – Cosela Prior Authorization Policy
- Cosela™ (trilaciclib intravenous infusion – G1 Therapeutics)

**REVIEW DATE:** 03/09/2022

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## OVERVIEW

Cosela, a cyclin dependent kinase (CDK) 4/6 kinase inhibitor, is indicated to **decrease the incidence of chemotherapy-induced myelosuppression** in adults when administered prior to a platinum/etoposide-containing regimen or topotecan-containing regimen for extensive-stage small cell lung cancer (SCLC).[1]

## Guidelines

Cosela is discussed in guidelines from the National Comprehensive Cancer Network (NCCN):[2,3]

- **Hematopoietic growth factors:** NCCN guidelines (version 1.2022 – December 22, 2021) recommend the use of Cosela for prophylactic management to decrease the incidence of anemia and red blood cell transfusions when administered before platinum/etoposide ± immune checkpoint inhibitor-containing regimens or a topotecan-containing regimen for extensive-stage SCLC (category 2B).[2] It has a category 2A recommendation to decrease the incidence of chemotherapy-induced myelosuppression when administered before (prophylactic granulocyte colony stimulating factor [G-CSF] may be administered after cycle 1) platinum/etoposide ± immune checkpoint inhibitor-containing regimens or a topotecan-containing regimen for extensive-stage SCLC . .
- **Small Cell Lung Cancer:** Under supportive care, the NCCN guidelines (version 2.2022 – November 24, 2021) note that Cosela or G-CSF may be used as prophylactic options to decrease the incidence of chemotherapy-induced myelosuppression when administering platinum/etoposide ± immune checkpoint inhibitor-containing regimens or a topotecan-containing regimen for extensive-stage SCLC (category 2A).[3]

## POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Cosela. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Cosela as well as the monitoring required for adverse events and long-term efficacy, approval requires Cosela to be prescribed by or in consultation with a physician who specializes in the condition being treated.

**Automation:** None.

## RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Cosela is recommended in those who meet the following criteria:

**FDA-Approved Indications**

1. **Small Cell Lung Cancer.** Approve for 6 months if the patient meets all of the following criteria (A, B, C, D, and E):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has extensive-stage disease; AND
   - **C)** The medication is used to decrease the incidence of chemotherapy-induced myelosuppression; AND
   - **D)** Patient meets ONE of the following criteria (i or ii):
     - **i.** Patient will be receiving a platinum (carboplatin or cisplatin) and etoposide-containing chemotherapy regimen; OR
     - **ii.** Patient will be receiving a topotecan-containing regimen; AND
   - **E)** The medication is prescribed by or in consultation with an oncologist.

## CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Cosela is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

## REFERENCES

1. Cosela™ intravenous infusion [prescribing information]. Durham, NC: G1 Therapeutics, Inc.; February 2021.
2. The NCCN Hematopoietic Growth Factors Clinical Practice Guidelines in Oncology (version 1.2022 – December 22, 2021). © 2021 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on March 4, 2022.
3. The NCCN Small Cell Lung Cancer Clinical Practice Guidelines in Oncology (version 2.2022 – November 4, 2021). © 2021 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on March 4, 2022.