

PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Pemazyre Prior Authorization Policy

- Pemazyre® (pemigatinib tablets – Incyte)

REVIEW DATE: 05/04/2022; selected revision 06/22/2022 and 09/14/2022

OVERVIEW

Pemazyre, a kinase inhibitor, is indicated in adults for the following uses:¹

- Previously treated, unresectable locally advanced or metastatic **cholangiocarcinoma** with a fibroblast growth factor receptor 2 (*FGFR2*) fusion or other rearrangement as detected by an FDA-approved test.
- Relapsed or refractory **myeloid/lymphoid neoplasms** with fibroblast growth factor receptor 1 (*FGFR1*) rearrangement.

Guidelines

Pemazyre is addressed in National Comprehensive Cancer Network (NCCN) guidelines:²

- **Hepatobiliary cancers:** NCCN guidelines (version 1.2022 – March 29, 2022) recommend Pemazyre for disease progression on or following systemic treatment for patients with unresectable or metastatic cholangiocarcinoma with *FGFR2* fusion or rearrangement, as a single agent (category 2A).³
- **Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes:** NCCN guidelines (version 1.2022 – April 14, 2022) recommend Pemazyre for the treatment of myeloid/lymphoid neoplasms with eosinophilia and *FGFR1* rearrangement in chronic phase or blast phase (category 2A).⁴ Treatment in a clinical trial is preferred, if available, rather than off-label use.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Pemazyre. All approvals are provided for the duration noted below.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

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

FDA-Approved Indications

1. **Cholangiocarcinoma.** Approve for 1 year if the patient meets ALL of the following criteria (A, B, C, and D):
 - A) Patient is ≥ 18 years of age; AND
 - B) Patient has unresectable locally advanced or metastatic disease; AND
 - C) Tumor has fibroblast growth factor receptor 2 (*FGFR2*) fusion or other rearrangement, as detected by an approved test; AND
 - D) Patient has been previously treated with at least one systemic regimen.

Note: Examples of systemic regimens are gemcitabine + cisplatin, 5-fluorouracil + oxaliplatin or cisplatin, capecitabine + cisplatin or oxaliplatin, gemcitabine + Abraxane (albumin-bound paclitaxel) or capecitabine or oxaliplatin, gemcitabine + Abraxane + cisplatin, FOLFOX (5-fluorouracil, leucovorin, and oxaliplatin), FOLFIRI (5-fluorouracil, leucovorin, irinotecan), Stivarga (regorafenib tablets).

2. Myeloid/Lymphoid Neoplasms. Approve for 1 year if the patient meets ALL of the following criteria (A, B, C, and D):

A) Patient is \geq 18 years of age; AND

B) Patient has eosinophilia; AND

C) The cancer has fibroblast growth factor receptor 1 (*FGFR1*) rearrangement, as detected by an approved test; AND

D) The cancer is in chronic phase or blast phase.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Pemazyre 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. Pemazyre® tablets [prescribing information]. Wilmington, DE: Incyte; August 2022.
2. The NCCN Drugs & Biologics Compendium. © 2022 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed September 6, 2022. Search term: pemigatinib.
3. The NCCN Hepatobiliary Cancers Clinical Practice Guidelines in Oncology (version 1.2022 – March 29, 2022). © 2022 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on May 2, 2022.
4. The NCCN Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes Clinical Practice Guidelines in Oncology (version 1.2022 – April 14, 2022). © 2022 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on September 6, 2022.