

## PHARMACY COVERAGE GUIDELINE

### IWILFIN™ (eflornithine) oral Generic Equivalent (if available)

#### **This Pharmacy Coverage Guideline (PCG):**

- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively “Service”) is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider’s judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member’s benefit plan; and
- Is subject to change as new information becomes available.

#### **Scope**

- This PCG applies to Commercial and Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

#### **Instructions & Guidance**

- To determine whether a member is eligible for the Service, read the entire PCG.
- This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
- Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
- The “Criteria” section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member’s benefit plan.
- The “Description” section describes the Service.
- The “Definition” section defines certain words, terms or items within the policy and may include tables and charts.
- The “Resources” section lists the information and materials we considered in developing this PCG
- **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
- Information about medications that require prior authorization is available at [www.azblue.com/pharmacy](http://www.azblue.com/pharmacy). You must fully complete the [request form](#) and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to [Pharmacyprecert@azblue.com](mailto:Pharmacyprecert@azblue.com).

#### **Criteria:**

- **Criteria for initial therapy:** Iwilfin (eflornithine) and/or generic equivalent (if available) is considered ***medically necessary*** and will be approved when **ALL** the following criteria are met:
1. Prescriber is a physician specializing in the patient’s diagnosis or is in consultation with an Oncologist
  2. Individual has a confirmed diagnosis of **ONE** of the following:
    - a. Adult or pediatric individual (1 year of age or older) with high-risk neuroblastoma (HRNB) who has demonstrated at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy (e.g., Unituxin (dinutuximab)) who is at risk for relapse

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- b. Other request for a specific oncologic direct treatment use that is found and listed in the National Comprehensive Cancer Network (NCCN) Guidelines with Categories of Evidence and Consensus of 1 and 2A
3. Individual has received and completed **ALL** the following **baseline tests** before initiation of treatment and with continued monitoring of the individual as clinically appropriate:
  - a. Audiogram
  - b. Complete blood count
  - c. Liver function tests (alanine aminotransferase (ALT), aspartate aminotransferase (AST), bilirubin)
  - d. There is a negative pregnancy test in a woman of childbearing potential
  - e. Lansky score is at least 60 or more
4. **If available:** Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for a **generic equivalent** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] ([see Definitions section](#))

**Initial approval duration:** 6 months

- **Criteria for continuation of coverage (renewal request):** Iwilfin (eflornithine) and/or generic equivalent (if available) is considered **medically necessary** and will be approved when **ALL** the following criteria are met (**samples are not considered for continuation of therapy**):
1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with an Oncologist
  2. Individual's condition has responded while on therapy with response defined as the following:
    - a. There is no evidence of disease progression
    - b. There is no evidence of unacceptable drug toxicity
  3. Individual has been adherent with the medication
  4. Requested dose is at least 192 mg once daily
  5. **If available:** Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for a **generic equivalent** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] ([see Definitions section](#))
  6. Individual has not developed any significant adverse drug effects that may exclude continued use such as:
    - a. Severe/serious or life-threatening myelosuppression (e.g., neutropenia, thrombocytopenia, bone marrow failure, anemia)
    - b. Hepatotoxicity
    - c. Hearing loss
    - d. Other life-threatening adverse effect thought to be drug related that recurs after dose interruption and dose reduction

**Renewal duration:** 12 months (Total duration of treatment is 2 years)

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- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. Off-Label Use of Non-Cancer Medications
2. Off-Label Use of Cancer Medications

#### **Description:**

Iwilfin (eflornithine) is an ornithine decarboxylase inhibitor indicated to reduce the risk of relapse in adult and pediatric individuals with high-risk neuroblastoma (HRNB) who have demonstrated at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy.

HRNB remains a challenge in pediatric oncology, accounting for 15% of all pediatric cancer deaths. While most patients are able to attain remission, approximately 50% will relapse. Once relapsed, there is currently no curative treatment for these children, and for these children the 5-year survival rate is <10%.

Neuroblastomas are neuroblastic tumors of children. Segmental chromosomal aberrations (SCAs), particularly segmental deletions of chromosome 1p, are associated with a poor prognosis. Deletions of chromosome 1p are associated with amplification of the *MYCN* oncogene (also called *N-myc*), the most common focal genetic lesion in sporadic neuroblastoma. The presence or absence of alterations in total DNA content and the amplification of *MYCN* are important in determining the appropriate therapy for newly diagnosed patients. The definitive diagnosis of neuroblastoma is made by histologic confirmation, either from biopsy of tumor tissue or evidence of metastases to bone marrow on aspirate or biopsy with concomitant elevation of catecholamines in the urine. The treatment of neuroblastoma is determined based on low-, intermediate-, and high-risk categories based on tumor stage and other clinical characteristics at diagnosis (including age and molecular/pathologic features).

#### **Definitions:**

U.S. Food and Drug Administration (FDA) MedWatch Forms for FDA Safety Reporting  
[MedWatch Forms for FDA Safety Reporting | FDA](#)

#### **Lansky Scale:**

Score	Description
100	Fully active, normal
90	Minor restrictions in physical strenuous activity
80	Active, but tires more quickly
70	Both greater restriction of, and less time spent in, play activity
60	Up and around, but minimal active play; keeps busy with quieter activities
50	Gets dressed, but lies around much of the day; no active play; able to participate in all quiet play and activities
40	Mostly in bed, participates in quiet activities

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30	In bed, needs assistance even for quiet play
20	Often sleeping, play entirely limited to very passive activities
10	No play, does not get out of bed
0	Dead

#### Resources:

Iwilfin (eflornithine) tab product information, revised by USWM, LLC. 12-2023. Available at DailyMed <http://dailymed.nlm.nih.gov>. Accessed December 10, 2024.

Shohet JM, Nuchtern JG. Epidemiology, pathogenesis, and pathology of neuroblastoma. In: UpToDate, Park JR, Shah SM (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at <http://uptodate.com>. Literature current through December 2024. Topic last updated on February 16, 2024. Accessed January 28, 2025.

Shohet JM, Nuchtern JG, Foster JH. Clinical presentation, diagnosis, and staging evaluation of neuroblastoma. In: UpToDate, Park JR, Shah SM (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at <http://uptodate.com>. Literature current through December 2024. Topic last updated on April 05, 2024. Accessed January 28, 2025.

Shohet JM, Nuchtern JG, Foster JH. Treatment and prognosis of neuroblastoma. In: UpToDate, Park JR, Shah SM (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at <http://uptodate.com>. Literature current through December 2024. Topic last updated on December 12, 2024. Accessed January 28, 2025.

Osterheld J, Ferguson W, Kravaka JM, et al.: Eflornithine as Postimmunotherapy Maintenance in High-Risk Neuroblastoma: Externally Controlled, Propensity Score–Matched Survival Outcome Comparisons. J Clin Oncol 2023;42(1):90-102. Re-evaluated January 28, 2025.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Neuroblastoma Version 2.2024 – Updated July 02, 2024. Available at <https://www.nccn.org>. Accessed January 28, 2025.

ClinicalTrials.gov Bethesda (MD): National Library of Medicine (US). Identifier NCT02395666: A Phase II Preventative Trial of DFMO (Eflornithine HCl) as a Single Agent in Patients With High Risk Neuroblastoma in Remission. Available from: <http://clinicaltrials.gov>. Last update posted December 06, 2023. Last verified December 2023. Accessed February 08, 2024. Re-evaluated January 28, 2025.

Off Label Use of Cancer Medications: A.R.S. §§ 20-826(R) & (S). Subscription contracts; definitions.

Off Label Use of Cancer Medications: A.R.S. §§ 20-1057(V) & (W). Evidence of coverage by health care service organizations; renewability; definitions.

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