PHARMACY COVERAGE GUIDELINE

RETEVMO™ (selpercatinib) 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/or 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. 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.

Medical Necessity Requirements for RETEVMO (selpercatinib)

Criteria for Initial Therapy:

Prescriber Qualifications
- Prescribed by an Oncologist or in consultation with one

Indication
- Locally advanced or metastatic non small cell lung cancer (NSCLC) with rearranged during transfection (RET) gene fusion, detected by an FDA approved test
- Advanced or metastatic medullary thyroid cancer (MTC) with RET mutation, detected by an FDA approved test, requiring systemic therapy

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- Advanced or metastatic thyroid cancer with RET gene fusion, detected by an FDA approved test, requiring systemic therapy and radioactive iodine refractory (if appropriate)
- Locally advanced or metastatic solid tumors with RET gene fusion, detected by an FDA approved test, that have progressed on or following prior systemic treatment or have no satisfactory alternative treatment options
- Other oncologic direct treatment uses listed in National Comprehensive Cancer Network (NCCN) Guidelines with Categories of Evidence and Consensus of 1 and 2A

Age Requirement

- Thyroid cancer or solid tumors: 2 years or older
- NSCLC: 18 years or older

Baseline Clinical Evaluation

- Blood pressure is adequately controlled
- Electrocardiogram (ECG) to assess QT interval
- Potassium, magnesium, and calcium levels are within normal ranges
- Thyroid stimulating hormone (TSH) level
- Negative pregnancy test (if applicable)
- Eastern Cooperative Oncology Group (ECOG) Performance Status is 0 to 2

Brand Specific Criteria

- Have failure, contraindication or intolerance with **THREE** generic equivalents (when available) for at least three months each. **Note:** Any failure, contraindication, or intolerance to the generic drugs should be reported to the FDA (see Definitions section)

Safety

- **NONE** of the following:
  - Active cardiovascular disease or recent myocardial infarction
  - End stage renal disease (eGFR rate less than 15 mL/min)
  - Concomitant use of strong or moderate CYP3A inducers (e.g., carbamazepine, phenobarbital, phenytoin, rifampin, bosentan, dexamethasone, nafcillin, rifabutin, St. John’s wort, etc.)

Documentation Requirements

- A completed request form must be submitted, including:
  - Chart notes
  - Lab results (blood pressure, EKG, potassium, magnesium, calcium, TSH, pregnancy test, ECOG status)
  - Supporting clinical documentation

Initial Therapy Criteria Approval Duration

- 6 months OR end of plan year

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Criteria for Continuation of Therapy (renewal therapy)

Note: Manufacturer assistance (e.g., coupons, samples, etc.) are not considered for continuation of therapy

Prescriber Qualification

- Continues to be seen by an Oncologist or in consultation with one

Clinical Response

- No evidence of disease progression or unacceptable toxicity

Adherence

- Adherence to the prescribed therapy regimen has been documented

Safety

- **NONE** of the following:
  - Active cardiovascular disease or recent myocardial infarction
  - End stage renal disease (eGFR rate less than 15 mL/min)
  - Concomitant use of strong or moderate CYP3A inducers (e.g., carbamazepine, phenobarbital, phenytoin, rifampin, bosentan, dexamethasone, nafcillin, rifabutin, St. John's wort, etc.)
  - More than 3 dose reductions due to drug toxicity
  - Development of significant adverse drug effects such as:
    1. Hepatotoxicity
    2. Recurrent moderate or severe/life threatening interstitial lung disease or pneumonitis
    3. Life threatening hypertension not controlled by antihypertensive medications
    4. Life threatening QT prolongation
    5. Severe or life threatening hemorrhage
    6. Recurrence of severe or life threatening hypersensitivity
    7. Severe or life threatening hypothyroidism

Brand Specific Criteria

- Have failure, contraindication or intolerance with **THREE** generic equivalents (when available) for at least three months each. **Note:** Any failure, contraindication, or intolerance to the generic drugs should be reported to the FDA (see Definitions section)

Documentation Requirements

- Chart notes
- Supporting clinical documentation with evidence of improvement in given indication
- Lab values that confirm safe use from above criteria

Continuation Therapy Criteria Approval Duration

- 12 months OR end of plan year

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Criteria for Off-Label Use Requests:

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:

Retevmo (selpercatinib) is indicated for the treatment of adult patients (18 years of age or older) with metastatic *RET* fusion-positive non-small cell lung cancer (NSCLC); for the treatment of adult and pediatric patients 2 years of age and older with advanced or metastatic *RET*-mutant medullary thyroid cancer (MTC) who require systemic therapy; for the treatment of adult and pediatric patients 2 years of age and older with advanced or metastatic *RET* fusion-positive thyroid cancer who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate); and for the treatment of adult and pediatric patients 2 years of age and older with locally advanced or metastatic solid tumors with a *RET* gene fusion that have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options.

Use of Retevmo (selpercatinib) for other *RET* fusion-positive solid tumors is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).

Definitions:

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

Activities of daily living (ADL):
Instrumental ADL:
Prepare meals, shop for groceries or clothes, use the telephone, manage money, etc.
Self-care ADL:
Bathe, dress and undress, feed self, use the toilet, take medications, not bedridden

Common Terminology Criteria for Adverse Events (CTCAE) Version 4.0:

Grade 1	Mild; asymptomatic or mild symptoms; clinical or diagnostic observations only; intervention not indicated
Grade 2	Moderate; minimal, local or noninvasive intervention indicated; limiting age-appropriate instrumental ADL*
Grade 3	Severe or medically significant but not immediately life-threatening; hospitalization or prolongation of hospitalization indicated; disabling; limiting self-care ADL**
Grade 4	Life-threatening consequences; urgent intervention indicated
Grade 5	Death related to AE
U.S. Department of Health and Human Services, National Institutes of Health, and National Cancer Institute	

ECOG Performance status:

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Eastern Co-operative Oncology Group (ECOG) Performance Status	
Grade	ECOG description
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work
2	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours
3	Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours
4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair
5	Dead
Oken, M.M., Creech, R.H., Tormey, D.C., Horton, J., Davis, T.E., McFadden, E.T., Carbone, P.P.: Toxicity And Response Criteria Of The Eastern Cooperative Oncology Group. Am J Clin Oncol 5:649-655, 1982	

NCCN recommendation definitions:

Category 1:
Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2A:
Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2B:
Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
Category 3:
Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate

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Resources:

Retevmo (selpercatinib) product information, revised by Eli Lilly and Company 12-2024. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed May 10, 2025.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology: Non-Small Cell Lung Cancer. Version 3.2025. Updated January 14, 2025. Available at https://www.nccn.org. Accessed May 10, 2025.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology: Thyroid Carcinoma. Version 01.2025. Updated March 27, 2025. Available at https://www.nccn.org. Accessed May 10, 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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