BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINE

Temozolomide oral capsule

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. 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.

Criteria:

- **Criteria for initial therapy:** Generic temozolomide 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 is 18 years of age or older

  3. Individual has a confirmed diagnosis of **ONE** of the following:
     a. Newly diagnosed glioblastoma used concomitantly with radiotherapy and then as maintenance treatment

     b. Adjunctive treatment in newly diagnosed anaplastic astrocytoma

c. Treatment of refractory anaplastic astrocytoma

d. 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

4. 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. Complete blood count (CBC) with differential
   b. Absolute neutrophil count (ANC) of 1.5 x 10^9 /L or greater and a platelet count of 100 x 10^9 /L or greater
   c. Liver function tests
   d. Negative pregnancy test in a woman of childbearing potential

5. There are **NO** FDA-label contraindications such as patients who have a history of hypersensitivity to dacarbazine (DTIC)

6. Individual does not have severe renal impairment (CrCl less than 36 mL/min/m^2) or for individuals with end-stage renal disease on dialysis

7. Individual does not have severe hepatic impairment (Child-Pugh Class C)

Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Generic temozolomide 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. Documented evidence of efficacy, disease stability and/or improvement
   b. No evidence individual has developed any significant unacceptable adverse drug reactions that may exclude continued use

3. Individual has been adherent with the medication

4. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use as follows:
   a. Contraindications as listed in the criteria for initial therapy section
   b. Significant adverse effect such as:
      i. Severe myelosuppression (e.g., pancytopenia, leukopenia, neutropenia, thrombocytopenia, anemia)
      ii. Severe hepatotoxicity
      iii. Pneumocystis Pneumonia (PCP)

5. Individual does not have severe renal impairment (creatinine clearance (CrCl) less than 36 mL/min/m^2) or for individuals with end-stage renal disease on dialysis

6. Individual does not have severe hepatic impairment (Child-Pugh Class C)

Renewal duration: 12 months

- 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:

Temozolomide is indicated for the treatment of adult patients with newly diagnosed glioblastoma multiforme used concomitantly with radiotherapy and then as maintenance treatment and for the treatment of adult patients with refractory anaplastic astrocytoma in patients who have experienced disease progression on a drug regimen containing nitrosourea and procarbazine.

Temozolomide is not directly active but spontaneously undergoes rapid non-enzymatic conversion at physiologic pH to the reactive compound 5-(3-methyltriazen-1-yl)-imidazole-4-carboxamide (MTIC). MTIC is further hydrolyzed to 5-amino-imidazole-4-carboxamide (AIC), which is known to be an intermediate in purine and nucleic acid biosynthesis, and to methylhydrazine, which is believed to be the active alkylating species. Cytotoxicity is thought to be primarily due to alkylation of DNA. Alkylation (methylation) occurs mainly at the O^6 and N^7 positions of guanine.

Definitions:

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

Resources:

Temodar (temozolomide) cap information, revised by Merck Sharp & Dohme LLC. 09-2023. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed December 09, 2024.

Temozolomide cap product information, revised by Amneal Pharmaceuticals LLC. 02-2024. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed January 30, 2025.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Central Nervous System Cancers Version 4.2024 – Updated January 21, 2025. Available at https://www.nccn.org. Accessed January 30, 2025.

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

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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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