BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINE

VERZENIO™ (abemaciclib) 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 VERZENIO (abemaciclib)

Criteria for Initial Therapy:

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

Indication
- HR-positive, HER2-negative, node-positive, early breast cancer at high risk of recurrence for adjuvant treatment in combination with endocrine therapy (tamoxifen or an aromatase inhibitor)
- For men and postmenopausal women with HR-positive, HER2-negative advanced or metastatic breast cancer in combination with an aromatase inhibitor as initial endocrine-based therapy

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- HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy in combination with fulvestrant
- HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy and prior chemotherapy in the metastatic setting used as monotherapy
- 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
- 18 years or older

Baseline Clinical Evaluation
- Negative pregnancy test for women of childbearing age
- Eastern Cooperative Oncology Group (ECOG) Performance Status of 0 or 1

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 United States Food and Drug Administration (FDA)

Safety
- No concomitant use with moderate or strong CYP3A inducers (e.g., armodafinil, bexarotene, bosentan, rifampin, rifabutin, phenobarbital, carbamazepine, etc.)
- No concomitant oral ketoconazole

Documentation Requirements
- A completed request form must be submitted, including:
  - Chart notes
  - Lab results (pregnancy test, ECOG status)
  - Supporting clinical documentation

Initial Therapy Criteria Approval Duration
- 6 months OR end of plan year

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 a physician specializing in or is in consultation with an Oncologist

Clinical Response
- No evidence of disease progression or unacceptable toxicity

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Adherence

- Adherence to the prescribed therapy regimen has been documented

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

- No significant adverse drug effects such as:
  - Elevation in AST and/or ALT greater than 3 times ULN with total bilirubin greater than 2 times ULN in the absence of cholestasis
  - Life-threatening hepatotoxicity (greater than 20 times ULN)
  - Severe or life-threatening interstitial lung disease/pneumonitis
- No concomitant use with moderate or strong CYP3A inducers (e.g., armodafinil, bexarotene, bosentan, rifampin, rifabutin, phenobarbital, carbamazepine, etc.)
- No concomitant oral ketoconazole

Documentation Requirements

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

Continuation Therapy Criteria Approval Duration

- 12 months OR end of plan year

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:

Verzenio (abemaciclib) is indicated in combination with endocrine therapy (tamoxifen or an aromatase inhibitor) for the adjuvant treatment of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node-positive, early breast cancer at high risk of recurrence; in combination with an aromatase inhibitor as initial endocrine-based therapy for the treatment of postmenopausal women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer; in

combination with fulvestrant for the treatment of women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer with disease progression following endocrine therapy and as monotherapy for the treatment of adult patients with HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy and prior chemotherapy in the metastatic setting.

Abemaciclib is an inhibitor of cyclin-dependent kinases 4 and 6 (CDK4 and CDK6). These kinases are activated upon binding to D-cyclins. In estrogen receptor-positive (ER+) breast cancer cell lines, cyclin D1 and CDK4/6 promote phosphorylation, cell cycle progression, and cell proliferation. Abemaciclib inhibits phosphorylation and blocks progression cell cycle phases G1 moving into S phase, resulting in senescence and apoptosis. In breast cancer models, abemaciclib as a single agent or in combination with antiestrogens resulted in reduction of tumor size.

Definitions:

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

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

ECOG Performance status:

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 house work, 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	

CDK 4/6 inhibitors:
Verzenio (abemaciclib)

Ibrance (palbociclib)
Kisqali (ribociclib)

Aromatase Inhibitors:
Arimidex (anastrozole)
Femara (letrozole)
Aromasin (exemestane)

Antiestrogens:
Faslodex (fulvestrant)
Tamoxifen
Fareston (toremifene)

Gonadotropin-Releasing Hormone Analog – for men with breast cancer along with aromatase inhibitors:
Zoladex (goserelin)
Vantas (histrelin)
Eligard, Lupron (leuprolide)
Trelstar (triptorelin)
Progestin Combination

Antiandrogens:
Zytiga, Yonsa (abiraterone)
Erleada (apalutamide)
Casodex (bicalutamide)
Xtandi (enzalutamide)
Flutamide
Nilandron (nilutamide)

Resources:

Verzenio (abemaciclib) product information, revised by Eli Lilly and Company 11-2024. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed February 21, 2025.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Breast Cancer Version 4.2025 – Updated April 17, 2025. Available at https://www.nccn.org. Accessed April 01, 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.