Clinical Policy: Azacitidine (Onureg, Vidaza)

Reference Number: CP.PHAR.387
Effective Date: 12.01.18
Last Review Date: 11.23
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Azacitidine (Onureg®, Vidaza®) is a nucleoside metabolic inhibitor.

FDA Approved Indication(s)

Onureg is indicated for continued treatment of adult patients with acute myeloid leukemia (AML) who achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy and are not able to complete intensive curative therapy.

Vidaza is indicated for the treatment of:

- Adult patients with the following French-American-British (FAB) myelodysplastic syndrome (MDS) subtypes: refractory anemia (RA) or refractory anemia with ringed sideroblasts (RARS) (if accompanied by neutropenia or thrombocytopenia or requiring transfusions), refractory anemia with excess blasts (RAEB), refractory anemia with excess blasts in transformation (RAEB-T), and chronic myelomonocytic leukemia (CMMoL).
- Pediatric patients aged 1 month and older with newly diagnosed juvenile myelomonocytic leukemia (JMML).

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Onureg and Vidaza are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Myelodysplastic Syndromes (must meet all)**:**

1. Diagnosis of MDS, including JMML;
2. Request is for Vidaza;
3. Prescribed by or in consultation with an oncologist or hematologist;
4. One of the following (a or b):
   a. Age ≥ 18 years;
   b. Age ≥ 1 month, and request is for JMML;
5. Request meets one of the following (a, b, or c):*
   a. For MDS, dose does not exceed one of the following (i or ii):
      i. Initial: 75 mg/m^2 per day for 7 days;
      ii. Maintenance: 100 mg/m^2 per day for 7 days per 4-week cycle;

b. For JMML, dose does not exceed one of the following administered daily for 7 days per 28-day cycle, for up to 6 cycles (i or ii):
   i. Age 1 month to less than 1 year or weighing less than 10 kg: 2.5 mg/kg;
   ii. Age 1 year and older and weighing 10 kg or greater: 75 mg/m^2;
c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Acute Myeloid Leukemia (Vidaza off-label) (must meet all)**:**
1. Diagnosis of AML;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. For Onureg requests, member meets all of the following (a, b, c, and d):
   a. Request is for maintenance therapy;
   b. Request is for single-agent therapy;
   c. Member achieved CR or CRi following intensive induction chemotherapy and is either not able or declines to complete intensive consolidation/curative therapy (*see Appendix D*);
   d. One of the following (i or ii):
      i. Medical justification supports inability to use SC/IV azacitidine (e.g., contraindication to excipients);
      ii. Request is for treatment associated with cancer for a State with regulations against step therapy in certain oncology settings (see Appendix E);
5. For Onureg requests, member must use generic azacitidine, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Request meets one of the following (a, b, or c):*
   a. Onureg: Dose does not exceed 300 mg (1 tablet) per day for 14 days per 4-week cycle;
   b. Vidaza: Dose does not exceed 100 mg/m^2 per day for 7 days per 4-week cycle;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months
Commercial – Onureg: 6 months; Vidaza: 6 months or to the member's renewal date, whichever is longer

C. Myelofibrosis (off-label) (must meet all)**:**
1. Diagnosis of advanced phase (i.e., accelerated- or blast-phase) myelofibrosis (MF);
2. Request is for Vidaza;
3. Prescribed by or in consultation with an oncologist or hematologist;
4. Age ≥ 18 years;
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 100 mg/m^2 per day for 7 days per 4-week cycle;

b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months
Commercial – 6 months or to the member's renewal date, whichever is longer

D. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Vidaza or Onureg for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Onureg requests, member must use generic azacitidine, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, request meets one of the following (a, b, c, or d):*
   a. Onureg: New dose does not exceed 300 mg (1 tablet) per day for 14 days per 4-week cycle;
   b. Vidaza for MDS: New dose does not exceed 100 mg/m^2 per day for 7 days per 4-week cycle;
   c. Vidaza for JMML: New dose does not exceed one of the following administered daily for 7 days per 28-day cycle, for up to 6 cycles (i or ii):
      i. Age 1 month to less than 1 year or weighing less than 10 kg: 2.5 mg/kg;
      ii. Age 1 year and older and weighing 10 kg or greater: 75 mg/m^2;
   d. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 12 months

Commercial – Onureg: 12 months; Vidaza: 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AML: acute myelogenous leukemia
ANC: absolute neutrophil count
CMMoL/CMML: chronic myelomonocytic leukemia
CR: complete response
CRi: complete response with incomplete hematologic recovery
FAB: French-American-British
FDA: Food and Drug Administration
JMML: juvenile myelomonocytic leukemia
MDS: myelodysplastic syndrome
MF: myelofibrosis
NCCN: National Comprehensive Cancer Network
RA: refractory anemia
RAEB: refractory anemia with excess blasts
RAEB-T: refractory anemia with excess blasts in transformation
RARS: refractory anemia with ringed sideroblasts

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings:

- Contraindication(s): advanced malignant hepatic tumors (Vidaza only), hypersensitivity to azacitidine (or mannitol for Vidaza only)
- Boxed warning(s): none reported

Appendix D: General Information

The National Comprehensive Cancer Network (NCCN) AML treatment guidelines define morphologic CR in patients that are independent of transfusions as follows:

- Absolute neutrophil count (ANC) > 1,000/mcL (blasts < 5%)
- Platelets ≥ 100,000/mcL (blasts < 5%)

NCCN presents CRi (a variant of CR) for AML as follows based on clinical trial information:

- < 5% marrow blasts
- Either ANC < 1,000/mcL or platelets < 100,000/mcL
- Transfusion independence but with persistence of neutropenia (<1,000/mcL) or thrombocytopenia (<100,000/mcL)

Appendix E: States with Regulations against Redirections in Certain Oncology Settings

State	Step Therapy Prohibited?	Notes
FL	Yes	For stage 4 metastatic cancer and associated conditions.
GA	Yes	For stage 4 metastatic cancer. Redirection does not refer to review of medical necessity or clinical appropriateness.
IA	Yes	For standard of care stage 4 cancer drug use, supported by peer-reviewed, evidence-based literature, and approved by FDA.
LA	Yes	For stage 4 advanced, metastatic cancer or associated conditions. Exception if "clinically equivalent therapy, contains identical active ingredient(s), and proven to have same efficacy.
NV	Yes	Stage 3 and stage 4 cancer patients for a prescription drug to treat the cancer or any symptom thereof of the covered person
OH	Yes	**Applies to HIM requests only** For stage 4 metastatic cancer and associated conditions
OK	Yes	**Applies to HIM requests only** For advanced metastatic cancer and associated conditions
PA	Yes	For stage 4 advanced, metastatic cancer
TN	Yes	For advanced metastatic cancer and associated conditions
TX	Yes	For stage 4 advanced, metastatic cancer and associated conditions

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Azacitidine (Onureg)	AML	300 mg PO QD on days 1 through 14 of each 28-day cycle	300 mg/day for 14 days/cycle
Azacitidine (Vidaza)	MDS	75 mg/m^2 SC or IV infusion QD for 7 days. Repeat cycle every 4 weeks. May increase to 100 mg/m^2 (after 2	100 mg/m^2/day for 7 days/cycle

Drug Name	Indication	Dosing Regimen	Maximum Dose
		treatment cycles). Patients should be treated for a minimum of 4 to 6 cycles. Doses may be adjusted or delayed based on hematology lab values, renal function, or serum electrolytes. Continue treatment as long as the patient continues to benefit	
	JMML	Age 1 month to less than 1 year or weighing less than 10 kg: 2.5 mg/kg Age 1 year and older and weighing 10 kg or greater: 75 mg/m^2 Administer IV daily for 7 days in a 28-day cycle, for a minimum of 3 cycles and a maximum of 6 cycles	See dosing regimen

VI. Product Availability

Drug Name	Availability
Azacitidine (Onureg)	Tablets: 200 mg, 300 mg
Azacitidine (Vidaza)	Lyophilized powder in single dose vials: 100 mg

VII. References

1. Onureg Prescribing Information. Summit, NJ: Celgene Corporation; October 2022. Available at: https://onuregpro.com. Accessed June 30, 2023.
2. Vidaza Prescribing Information. Summit, NJ: Celgene Corporation; May 2022. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/050974s034lbl.pdf. Accessed June 30, 2023.
3. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed August 9, 2023.
4. National Comprehensive Cancer Network. Myelodysplastic Syndromes Version 1.2023. Available at http://www.nccn.org/professionals/physician_gls/pdf/mds.pdf. Accessed July 10, 2023.
5. National Comprehensive Cancer Network. Acute Myeloid Leukemia Version 4.2023. Available at http://www.nccn.org/professionals/physician_gls/pdf/aml.pdf. Accessed August 1, 2023.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9025	Injection, azacitidine, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2019 annual review: MDS – added options for use as bridge therapy while awaiting HSCT donor availability or in patients with clinically relevant thrombocytopenia/neutropenia or increased bone marrow blasts per NCCN; AML for members ≥ 60 years – added combination use with Nexavar and Venclexta and simplified uses as Vidaza can be used for both induction and maintenance therapy in elderly patients declining more aggressive therapy per NCCN; references reviewed and updated.	08.27.19	11.19
4Q 2020 annual review: MDS, MF, AML criteria collapsed in recognition of the interrelated transformative nature of the three disease states and to encompass new subtypes and treatment algorithms; RT2: added Onureg to policy; references reviewed and updated.	09.09.20	11.20
4Q 2021 annual review: added criteria that Onureg be administered as single-agent therapy and option that member could decline consolidation/curative therapy for Onureg request per NCCN compendium; updated NCCN definition of CR and CRi in General Information and Appendix D; modified reference from HIM.PHAR.21 to HIM.PA.154; for Onureg requests, added requirement for use of generic if available; references reviewed and updated.	08.06.21	11.21
For AML, added redirection bypass for states with regulations against redirections in Stage IV or metastatic cancer along with additional information in Appendix E; for Onureg added allowance for continuation of care in Section II.	12.15.21	
RT4: added additional indication for Vidaza in pediatric patients aged 1 month and older with newly diagnosed JMML per updated prescribing information; generalized oncology redirection bypass language.	05.26.22	
4Q 2022 annual review: no significant changes; references reviewed and updated. Template changes applied to other diagnoses/indications.	08.01.22	11.22
Updated Appendix E to include Oklahoma.	06.07.23	
4Q 2023 annual review: no significant changes; references reviewed and updated.	06.30.23	11.23

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical

policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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