Erlotinib Criteria

Prior Authorization-Facility (PA-F) Criteria for Use
May 2017

VA Pharmacy Benefits Management Services, Medical Advisory Panel, and VISN Pharmacist Executives

The following recommendations are based on medical evidence, clinician input, and expert opinion. The content of the document is dynamic and will be revised as new information becomes available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. THE CLINICIAN SHOULD UTILIZE THIS GUIDANCE AND INTERPRET IT IN THE CLINICAL CONTEXT OF THE INDIVIDUAL PATIENT. INDIVIDUAL CASES THAT ARE EXCEPTIONS TO THE EXCLUSION AND INCLUSION CRITERIA SHOULD BE ADJUDICATED AT THE LOCAL FACILITY ACCORDING TO THE POLICY AND PROCEDURES OF ITS P&T COMMITTEE AND PHARMACY SERVICES.

The Product Information should be consulted for detailed prescribing information.

See the VA National PBM-MAP-VPE Monograph on this drug at www.pbm.va.gov or http://vaww.pbm.va.gov for further information.

Exclusion Criteria If the answer to ANY item below is met, then the patient should NOT receive erlotinib.

☐ Care not provided by a VA or VA purchased care (e.g. Choice Program, Fee Basis) hematology/oncology provider.
☐ Unable to swallow whole or intact oral tablets.
☐ Plan to receive erlotinib in combination therapy with platinum-based chemotherapy.
☐ Pregnancy [i.e., known pregnancy or positive pregnancy test] or plan to become pregnant.
☐ Plan to receive erlotinib to treat primary malignancy of pancreatic carcinoma (See Issues for Consideration)

Inclusion Criteria The answers to the following must be fulfilled in order to meet criteria.

☐ Goals of care and role of Palliative Care consult has been discussed and documented.
☐ ECOG Performance Status 0-3*

For women of childbearing potential
☐ Pregnancy should be excluded prior to receiving erlotinib and the patient provided contraceptive counseling on potential risk vs. benefit of taking erlotinib if patient were to become pregnant

AND 1 of the following in metastatic non-small cell lung cancer (NSCLC) in patients whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation or other erlotinib-sensitive mutations. Mutation testing preferably in context of the Precision Oncology Program when appropriate. (See Issues for Consideration)

☐ First line treatment
☐ Maintenance therapy of locally advanced or metastatic non-small-cell lung cancer that has not progressed after a treatment course of platinum-based first-line chemotherapy
☐ Second-or greater line therapy after progression on at least one prior chemotherapy regimen

Dosage and Administration (see Product Information for complete dosing information)

For non-small cell lung cancer 150 mg taken on an empty stomach, i.e., at least one hour before or two hours after the ingestion of food. Treatment should continue until disease progression or unacceptable toxicity occurs. Due to tolerability issues and high sensitivity of some mutations at lower doses, considering starting dose at 100 mg daily and increase if tolerated after 2-4 weeks. (See Issues for Consideration)

Discontinue therapy in the presence of:
- Intestinal Lung Disease (ILD)
- Severe hepatic toxicity that does not improve significantly or resolve within three weeks (total bilirubin >3 X ULN or transaminases > 5 X ULN)
- Gastrointestinal perforation
- Severe bullous, blistering, or exfoliating skin condition
- Corneal perforation or severe ulceration

Withhold therapy:
- During evaluation for ILD
- For severe (CTCAE grade 3 or 4) renal toxicity; and consider discontinuation
- In patients with pre-existing hepatic impairment for total bilirubin levels >3 times ULN or transaminases >5 times ULN; consider discontinuation
- In patients with pre-existing hepatic impairment or biliary obstruction for doubling of bilirubin or tripling of transaminase values

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Updated versions may be found at http://www.pbm.va.gov or http://vaww.pbm.va.gov
over baseline; and consider discontinuation
- For persistent severe diarrhea not responsive to medical management
- For severe rash not responsive to medical management
- For keratitis of (NCI-CTC version 4) grade 3-4 or for grade 2 lasting more than 2 weeks
- For acute/worsening ocular disorders such as eye pain; and consider discontinuation

Dose Modifications for drug interactions:
Reduce erlotinib by 50mg increments:
- If severe reactions occur with simultaneous use of strong CYP3A4 inhibitors; avoid concomitant use.
- When restarting following withholding for dose-limiting toxicity that has resolved to baseline or ≤grade 1.

Increase erlotinib by 50 mg increments at 2 week intervals to a maximum of 450 mg as tolerated for:
- Concomitant use with CYP3A4 inducers, such as rifampin, rifabutin, rifapentline, phenytoin, carbamazepine, phenobarbital, or St. John's Wort. Increase doses by 50 mg increments. Avoid concomitant use, if possible.

Increase by 50 mg increments at 2 week intervals to a maximum of 300 mg:
- Concurrent cigarette smoking: Immediately reduce the dose of erlotinib to the recommended dose (150 mg or daily) upon cessation of smoking.

Concurrent stomach-acid reducing therapy (increased gastric pH decreases erlotinib plasma concentrations):
- For proton pump inhibitors, avoid concomitant use if possible.
- For H2 antagonists, take erlotinib 10 hours after H2 antagonist dose or at least 2 hours before the next H2 antagonist dose.
- For use with antacids, separate doses by several hours.

Monitoring
- At baseline and every cycle: CBC, basic metabolic panel, liver function tests

Issues for Consideration
- Pancreatic Cancer: Although approved for use with gemcitabine for 1st line therapy of metastatic pancreatic cancer, the clinical benefit is small. Consider other options first (e.g. clinical trial or FOLFIRINOX)
- Other erlotinib-sensitive EGFR mutations include: substitutions A289V, G719A, S7681, G718C, R108K, G598V, R222C, L62R, L861Q, P596L, V774M and indel non-frame shifting insertions or deletions between amino acids 740 and 780 in exons 19 and 20, transcript NM_005228. Mutation testing in second or subsequent-line therapy should be performed preferably through the Precision Oncology Program.
- Tolerability: Rash and diarrhea treatment-related adverse reactions can affect quality of life and may cause gaps in therapy. Preventive therapy for rash, beginning on day 1 of therapy, includes cleansing of skin with soap-free pH neutral cleansers, use of hydrophilic moisturizing creams (for example Eucerin or Aquaphor), broad-spectrum sunscreen and protective clothing, plus oral doxycycline 100-200 mg/day for at least 8 weeks (or minocycline 100 mg/day for at least 8 weeks). Diarrhea generally occurs early in therapy. Provide a prescription for loperamide and instructions for initiation of therapy (2 capsules/tablets at the start of diarrhea then one capsule/tablet after each diarrhea episode up to 8 capsules/tablets in 24 hours) and phone follow-up for further instructions unless loperamide is contraindicated.

Discontinuation
- Discontinue therapy for disease progression on imaging studies or intolerable adverse effects.


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