OncoHealth

Paclitaxel Protein Bound (Abraxane)

Effective Date: 5/2/22
Revision Date(s): 9/21, 11/22, 12/22, 7/23
Review Date: 7/18/23
Policy type: Medical Necessity

Authorizations are for 6 months, after which time they must be reviewed for efficacy, safety, and tolerability.

Taxol (conventional paclitaxel) and Taxotere (docetaxel) are preferred taxane agents for all indications except pancreatic cancer, ampullary adenocarcinoma, and biliary tract cancers. The member must have a contraindication to hypersensitivity pre-medications OR the member must have a history of hypersensitivity reaction to Taxol and/or Taxotere prior to approval of Abraxane.

Universal Criteria:

- Indication specific criteria should be consistent with FDA labeling, NCCN, or indication specific peer-reviewed literature.
- Dose and frequency should be consistent with FDA labeling, NCCN, or indication specific peer-reviewed literature.

Approval Criteria:

Unless otherwise noted above the review criteria used by OncoHealth to determine medical necessity for anticancer treatments and supportive agents include, but is not limited to:

- New drugs or regimens (combinations of drugs) approved by the United States Food and Drug Administration (FDA).
- Drugs and biologics may be used off-label if they are considered medically accepted or necessary if supported by any of the following 5 compendia below.
    - NCCN Drugs & Biologics Compendium® (Category 1 and 2a)
    - Clinical Pharmacology (Strong For)
    - American Hospital Formulary Service Drug Information (AHFS DI) (Level 1)
    - Thompson Micromedex DrugDex® (Class I and IIa)
    - Wolters Kluwer Lexi-Drugs® (Level A)
- Other use of drugs and biologics may be considered medically accepted if supported as safe and effective according to peer-reviewed articles from one of the following journals
    - American Journal of Medicine; Annals of Internal Medicine; Annals of Oncology; Annals of Surgical Oncology; Biology of Blood and Marrow Transplantation; Blood; Bone Marrow Transplantation; British Journal of Cancer; British Journal of Hematology; British Medical Journal; Cancer; Clinical Cancer Research; Drugs; European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology); Gynecologic Oncology; International

Journal of Radiation, Oncology, Biology, and Physics; The Journal of the American Medical Association, Journal of Clinical Oncology; Journal of the National Cancer Institute; Journal of the National Comprehensive Cancer Network (NCCN); Journal of Urology; Lancet; Lancet Oncology; Leukemia; The New England Journal of Medicine; Radiation Oncology
    - **Meeting abstracts and case reports are excluded from consideration.**
- Non-standard protocols may be approved based on unique clinical circumstances.

Billing

Drug Name	HCPCS Code	Description
Abraxane	J9264	Injection, paclitaxel protein-bound particles, 1 mg
Paclitaxel Protein-bound	J9259	Injection, paclitaxel protein-bound particles (american regent) not therapeutically equivalent to J9264, 1 mg

References

1. Abraxane. NCCN Drugs & Biologics Compendium. Available at: https://www.nccn.org/professionals/drug_compendium/content/. Accessed 7/18/2023
2. Abraxane [package insert]. Abraxis BioScience, LLC, Summit, NJ. Available at: https://packageinserts.bms.com/pi/pi_abraxane.pdf
3. Paclitaxel Protein-Bound Particles [package insert]. American Regent, Inc., Shirley, NY. Available at: https://americanregent.com/media/3397/ref-2269_paclitaxel-albumin-full-prescribing-information-rev-07-2022.pdf

Disclaimer

Consideration of medically necessary indications are based upon U.S. Food and Drug Administration (FDA) indications, recommended uses within the Centers of Medicare & Medicaid Services (CMS) five recognized compendia, including the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium (Category 1 or 2A recommendations), and peer-reviewed scientific literature eligible for coverage according to the CMS, Medicare Benefit Policy Manual, Chapter 15, section 50.4.5 titled, "Off-Label Use of Anti-Cancer Drugs and Biologics." This policy evaluates whether the drug therapy is proven to be effective based on published evidence-based medicine. OncoHealth reserves the right to request medical documentation as needed to validate medical necessity determinations.

Drug Coverage Policies are developed as needed, regularly reviewed, updated at least annually, and are subject to change. Other policies and coverage determination guidelines may apply. Federal and state regulatory requirements and member specific benefit plan documents, if applicable, must be reviewed prior to this Drug Coverage Policy. This Drug Coverage Policy is for informational purposes only and does not constitute medical advice or dictate how providers should practice medicine. This policy should not be reproduced, stored in a retrieval system, or altered from its original form without written permission from OncoHealth, Inc.

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Date	Updates
7/18/23	Policy updated indication specific criteria (Deleted Hepatobiliary indication due to updated NCCN Category 2B recommendation) and to include 505(b)(2) HCPCS
5/2/2022	Policy approved at P&T
10/14/22	Policy updated to include additional criteria for biliary tract cancers
11/7/22	Policy approved at P&T to include update from 10/14/22
12/12/22	Updated formatting and incorporated universal criteria
5/2/2022	Reviewed and no substantive changes needed