Clinical Policy: Mobocertinib (Exkivity)

Reference Number: CP.PHAR.559
Effective Date: 12.01.21
Last Review Date: 11.24
Line of Business: Commercial, HIM , Medicaid

Revision Log

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

Description

Mobocertinib (Exkivity®) is a kinase inhibitor.

FDA Approved Indication(s)*

Exkivity is indicated for the treatment of adult patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 20 insertion mutations, as detected by an FDA-approved test, whose disease has progressed on or after platinum-based chemotherapy.

This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

***Takeda, the manufacturer of Exkivity, will initiate voluntarily withdrawal of Exkivity after post-market data from the EXCLAIM-2 Phase 3 trial revealed Exkivity did not meet the requirements of the FDA Accelerated Approval regulation (*see Appendix D*).**

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 Exkivity is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Non-Small Cell Lung Cancer (must meet all)**:**

1. Provider attestation of acknowledgement of Takeda's request for withdrawal of product due to failure to demonstrate superior progression-free survival (PFS) compared to platinum-based chemotherapy;
2. Diagnosis of locally advanced or metastatic NSCLC;
3. Prescribed by or in consultation with an oncologist;
4. Age ≥ 18 years;
5. Disease is positive for epidermal growth factor receptor (EGFR) exon 20 insertion mutations;
6. Member has progressed on or after platinum-based therapy;
7. For brand Exkivity requests, member must use generic mobocertinib, if available, unless contraindicated or clinically significant adverse effects are experienced;

8. Request meets one of the following (a or b):*
   a. Dose does not exceed both of the following (i and ii):
      i. 160 mg per day;
      ii. 4 capsules per day;
   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: 6 months

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.

II. Continued Therapy

A. Non-Small Cell Lung Cancer (must meet all)**:**

1. Provider attestation of acknowledgement of Takeda's request for withdrawal of product due to failure to demonstrate superior progression-free survival (PFS) compared to platinum-based chemotherapy;
2. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Exkivity for NSCLC and has received this medication for at least 30 days;
3. Member is responding positively to therapy;
4. For brand Exkivity requests, member must use generic mobocertinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed both of the following (i and ii):
      i. 160 mg per day;
      ii. 4 capsules per day;
   b. 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: 12 months

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

FDA: Food and Drug Administration
EGFR: epidermal growth factor receptor
NSCLC: non-small cell lung cancer
PFS: progression free survival

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Platinum-based chemotherapy (e.g., cisplatin, carboplatin)	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindications: none reported
- Boxed warnings: QTc prolongation and Torsades de Pointes

Appendix D: Withdrawal from Market

- Takeda, the manufacturer of Exkivity, will initiate voluntarily withdrawal of Exkivity after post-market data from the EXCLAIM-2 Phase 3 trial revealed Exkivity did not meet the requirements of the FDA Accelerated Approval regulation.
  - Exkivity did not meet its primary endpoint of superior PFS compared to platinum-based chemotherapy for NCSLC with EGFR exon 20 insertion mutations.
- Exkivity remains available to prescribe while Takeda works with the FDA on withdrawal timing. Takeda will provide updates when and as appropriate.
  - For additional questions, please contact Takeda at 844-662-8532 or globaloncologymedinfo@takeda.com.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
NSCLC	160 mg PO QD	160 mg/day

VI. Product Availability

Capsule: 40 mg

VII. References

1. Exkivity Prescribing Information. Lexington, MA: Takeda Pharmaceuticals America, Inc.; September 2023. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/215310s003lbl.pdf. Accessed September 4, 2024.
2. ClinicalTrials.gov. TAK-788 as First-Line Treatment Versus Platinum-Based Chemotherapy for Non-Small Cell Lung Cancer (NSCLC) With EGFR Exon 20 Insertion Mutations. Available at: https://clinicaltrials.gov/study/NCT04129502. Accessed October 16, 2023.
3. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed October 16, 2023.
4. National Comprehensive Cancer Network. Non-Small Cell Lung Cancer. Version 3.2023. Available at: http://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed October 16, 2023.
5. Takeda. Takeda provides update on EXKIVITY® (mobocertinib). October 2, 2023. Available at: https://www.takeda.com/newsroom/newsreleases/2023/Takeda-Provides-Update-on-EXKIVITY-mobocertinib/. Accessed August 7, 2027.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	09.30.21	11.21
4Q 2022 annual review: no significant changes; added previously P&T-approved template redirection to generic equivalent, if available; references reviewed and updated. Template changes applied to other diagnoses/indications.	08.09.22	11.22
4Q 2023 annual review: RT4: added disclaimer about FDA and manufacturer withdrawal; added requirement for prescriber	08.11.23	11.23

Reviews, Revisions, and Approvals	Date	P&T Approval Date
attestation to all criteria sets; added Appendix D; references reviewed and updated.		
4Q 2024 annual review: no significant changes; references reviewed and updated	09.04.24	11.24

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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.