

Reference number(s)
1892-A

## SPECIALTY GUIDELINE MANAGEMENT

### ERBITUX® (cetuximab)

#### POLICY

##### I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

###### A. FDA-Approved Indications

1. Squamous Cell Carcinoma of the Head and Neck (SCCHN)  
Erbix is indicated:
  - a. In combination with radiation therapy for the initial treatment of locally or regionally advanced squamous cell carcinoma of the head and neck (SCCHN).
  - b. In combination with platinum-based therapy with fluorouracil for the first-line treatment of patients with recurrent locoregional disease or metastatic SCCHN.
  - c. As a single agent for the treatment of patients with recurrent or metastatic SCCHN for whom prior platinum-based therapy has failed.
2. K-Ras Wild-type, EGFR-expressing Colorectal Cancer (CRC)  
Erbix is indicated for the treatment of K-Ras wild-type, epidermal growth factor receptor (EGFR)-expressing, metastatic colorectal cancer (mCRC) as determined by an FDA-approved test:
  - a. In combination with FOLFIRI (irinotecan, fluorouracil, leucovorin) for first-line treatment,
  - b. In combination with irinotecan in patients who are refractory to irinotecan-based chemotherapy,
  - c. As a single agent in patients who have failed oxaliplatin- and irinotecan-based chemotherapy or who are intolerant to irinotecan.

###### Limitations of Use:

Erbix is not indicated for treatment of Ras-mutant colorectal cancer or when the results of the Ras mutation tests are unknown.

###### B. Compendial Uses

1. Colorectal cancer
2. Squamous cell carcinoma of the head and neck
3. Occult primary head and neck cancer
4. Penile cancer
5. Squamous cell skin cancer
6. Non-small cell lung cancer

All other indications are considered experimental/investigational and not medically necessary.

##### II. DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:

- A. Documentation of Ras wild-type status, where applicable.

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- B. Documentation of BRAF mutation status, where applicable.
- C. Documentation of EGFR expression, where applicable.

### III. CRITERIA FOR INITIAL APPROVAL

#### A. Colorectal Cancer

Authorization of 6 months may be granted for treatment of colorectal cancer, including appendiceal adenocarcinoma and anal adenocarcinoma, for unresectable/inoperable, advanced, or metastatic disease and the member has not previously experienced clinical failure on panitumumab when all of the following criteria are met:

1. The *RAS* (*KRAS* and *NRAS*) mutation status is negative (wild-type).
2. If Erbitux is used in combination with encorafenib (Braftovi), the tumor is positive for BRAF V600E mutation

#### B. Squamous Cell Carcinoma of the Head and Neck

Authorization of 6 months may be granted for treatment of squamous cell carcinoma of the head and neck when any of the following criteria is met:

1. Disease is locally or regionally advanced, unresectable, recurrent, persistent, or metastatic.
2. Member is unfit for surgery.
3. Erbitux will be used in combination with radiation.

#### C. Occult Primary Head and Neck Cancer

Authorization of 6 months may be granted as a single agent for treatment of occult primary head and neck cancer for sequential chemoradiation.

#### D. Penile Cancer

Authorization of 6 months may be granted as a single agent for subsequent treatment of metastatic penile cancer.

#### E. Squamous Cell Skin Cancer

Authorization of 6 months may be granted for treatment of squamous cell skin cancer for inoperable or incompletely resected regional disease, regional recurrence, or distant metastases.

#### F. Non-Small Cell Lung Cancer (NSCLC)

Authorization of 6 months may be granted for subsequent treatment of recurrent, advanced or metastatic NSCLC when the following criteria are met:

1. Erbitux will be used in combination with afatinib.
2. Erbitux will be used in members with a known sensitizing EGFR mutation following disease progression on EGFR tyrosine kinase inhibitor therapy.

### IV. CONTINUATION OF THERAPY

Authorization of 6 months may be granted for continued treatment in members requesting reauthorization for an indication listed in Section III when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

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## V. REFERENCES

1. Erbitux [package insert]. Branchburg, NJ: ImClone LLC; April 2019.
2. The NCCN Drugs & Biologics Compendium® © 2020 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed July 08, 2020.
3. Lexicomp [database online]. Hudson, OH: Lexi-Comp, Inc.; [http://online.lexi.com/lco/action/index/dataset/complete\\_ashp](http://online.lexi.com/lco/action/index/dataset/complete_ashp) [available with subscription]. Accessed (July 2020).