Clinical Policy: Mechlorethamine Gel (Valchlor)

Reference Number: CP.PHAR.381
Effective Date: 11.16.16
Last Review Date: 08.22
Line of Business: Commercial, HIM, Medicaid

Revision Log

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

Description

Mechlorethamine (MCH) gel (Valchlor®) is an alkylating drug also known as nitrogen mustard.

FDA Approved Indication(s)

Valchlor is indicated for the topical treatment of Stage IA and IB mycosis fungoides (MF)-type cutaneous T-cell lymphoma (CTCL) in patients who have received prior skin-directed therapy.

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

I. Initial Approval Criteria

A. Mycosis Fungoides/Sezary Syndrome (must meet all)**:**

1. Diagnosis of one of the following (a, b, or c):
   a. MF, stage IA-III;
   b. Sezary syndrome (SS), stage IV;
   c. Large cell transformation (associated with MF and SS);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Failure of at least one skin-directed therapy* (*see Appendix B),* unless contraindicated or clinically significant adverse effects are experienced;
   **Prior authorization may be required for skin directed therapy*
5. Request meets one of the following (a or b):*
   a. Dose does not exceed one application 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:
Medicaid/HIM – 6 months
Commercial – 12 months or duration of request, whichever is less

B. NCCN Recommended Uses (off-label) (must meet all)**:**

1. Diagnosis of one of the following (a, b, c, or d):
   a. Primary cutaneous B-cell lymphoma (subtype i or ii):
      i. Marginal zone lymphoma;

ii. Follicle center lymphoma;
b. Primary cutaneous CD30+ T-cell lymphoproliferative disorder (the following subtype only: lymphomatoid papulosis);
c. Adult T-cell leukemia/lymphoma (chronic or smoldering subtype);
d. Langerhans cell histiocytosis (LCH) with isolated skin disease;

2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Failure of at least one skin-directed therapy* (*see Appendix B),* unless contraindicated or clinically significant adverse effects are experienced;
   **Prior authorization may be required for skin directed therapy*
5. Dose is within FDA maximum limit for any FDA-approved indication or 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 – 12 months or duration of request, whichever is less

C. 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 Valchlor for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed one application 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:
Medicaid/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

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

CTCL: cutaneous T-cell lymphoma
FDA: Food and Drug Administration
LCH: Langerhans cell histiocytosis
MCH: mechlorethamine
MF: mycosis fungoides
NCCN: National Comprehensive Cancer Network
SS: Sezary syndrome

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
Skin-Directed Therapies • Topical corticosteroids (e.g., betamethasone, clobetasol) • Local radiation	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
• Topical retinoids (Targretin® [bexarotene], tazarotene [Avage®, Fabior®, Tazorac®]) • Phototherapy (UVB, NB-UVB, PUVA) • Topical imiquimod (Aldara®) • Total skin electron beam therapy		

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

- Contraindication(s): severe hypersensitivity to mechlorethamine
- Boxed warning(s): none reported

Appendix D: General Information

The Valchlor pivotal trial was designed to assess non-inferiority of Valchlor (0.02% MCH gel) versus 0.02% MCH as a compounded ointment (historically used for MF in the absence of FDA labeled topical MCH alternatives). Inclusion criteria included persistent or recurrent stage IA, IB and IIA disease. Prior skin-directed therapies included but were not limited to topical corticosteroids, phototherapy, topical and oral bexarotene and other retinoids, interferons, methotrexate, radiation, and topical MCH (the latter not within two years prior to study enrollment). Non-inferiority was confirmed.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Stage IA/IB MF	Thin film QD to affected areas of the skin	One application QD

VI. Product Availability

Gel: 0.016% w/w (equivalent to 0.02% mechlorethamine HCl), 60g tube

VII. References

1. Valchlor Prescribing Information. Malvern, PA: Ceptarin Therapeutics; January 2020. Available at: https://www.valchlor.com/pdfs/Valchlor-022120-USPI-Digital.pdf. Accessed April 11, 2022.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org. Accessed April 11, 2022.
3. National Comprehensive Cancer Network. Primary Cutaneous Lymphomas Version 1.2022. Available at: http://www.nccn.org. Accessed April 11, 2022.
4. National Comprehensive Cancer Network. T-Cell Lymphomas Version 2.2022. Available at: http://www.nccn.org. Accessed April 11, 2022.
5. National Comprehensive Cancer Network. Histiocytic Neoplasms Version 2.2021. Available at: http://www.nccn.org. Accessed April 11, 2022.

6. Lessin SR, Duvic M, Guitart J, et al. Topical chemotherapy in cutaneous T-cell lymphoma: positive results of a randomized, controlled, multicenter trial testing the efficacy and safety of a novel mechlorethamine, 0.02%, gel in mycosis fungoides. JAMA Dermatol. 2013; 149(1): 25-32.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2019 annual review: NCCN recommended uses expand MS from stage IA to IB to stage IA to III; other NCCN recommended uses added to section I.A and as a new section I.B.; references reviewed and updated.	05.14.19	08.19
3Q 2020 annual review: HIM line of business added; continuation duration extended to 12 months to align with other lines of business; references reviewed and updated.	05.12.20	08.20
3Q 2021 annual review: no significant changes; updated reference for HIM off-label use to HIM.PA.154 (replaces HIM.PHAR.21); references reviewed and updated.	03.17.21	08.21
3Q 2022 annual review: revised approval duration for commercial line of business from length of benefit to "12 months or duration of request, whichever is less"; added Langerhans cell histiocytosis to section B as NCCN recommended use (off label); no significant changes; references reviewed and updated.	04.11.22	08.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.22.22	

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.