

Clinical Policy: Talazoparib (Talzenna)

Reference Number: CP.PHAR.409

Effective Date: 03.01.19

Last Review Date: 05.22

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Talazoparib (Talzenna[™]) is a poly (ADP-ribose) polymerase (PARP) inhibitor.

FDA Approved Indication(s)

Talzenna is indicated for the treatment of adult patients with deleterious or suspected deleterious germline BRCA-mutated (gBRCAm) human epidermal growth factor receptor 2 (HER2)-negative locally advanced or metastatic breast cancer. Select patients for therapy based on an FDA-approved companion diagnostic for Talzenna.

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

I. Initial Approval Criteria

A. Breast Cancer (must meet all):

1. Diagnosis of recurrent, locally advanced, or metastatic breast cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age \geq 18 years;
4. For brand Talzenna requests, medical justification supports inability to use generic talazoparib, if available (e.g., contraindications to excipients);
5. Documentation of HER2-negative disease;
6. Mutations in the BRCA genes;
7. Member has not previously received a PARP inhibitor (e.g., Lynparza[®], Rubraca[®], Zejula[®]);
8. Request meets one of the following (a or b):*
 - a. Dose does not exceed 1 mg (1 capsule) 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. 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. Breast Cancer (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Talzenna for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For brand Talzenna requests, medical justification supports inability to use generic talazoparib, if available (e.g., contraindications to excipients);
4. If request is for a dose increase, request meets one of the following (a or b):*
 - a. New dose does not exceed 1 mg (1 capsule) 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*

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.

Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ADP: adenosine diphosphate	HER2: human epidermal growth factor receptor 2
BRCA: breast cancer gene	HR: hormone receptor
gBRCAm: mutations in the germline BRCA genes	NCCN: National Comprehensive Cancer Network
FDA: Food and Drug Administration	PARP: poly (ADP-ribose) polymerase

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information

- The FDA approved indication for talazoparib includes using the diagnostic tool BRACAnalysis CDx™ by Myriad Genetic Laboratories. It is available at <http://www.fda.gov/companiondiagnostics>.
- There is insufficient data regarding the use of consecutive PARP inhibitors. Most PARP inhibitor pivotal trials excluded prior PARP inhibitor use, the NCCN does not make any explicit recommendations (other than for ovarian cancer, where they state data is limited), and there are no randomized controlled trials evaluating such use.

IV. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Breast cancer	1 mg PO QD For patients with moderate renal impairment (CrCl 30 – 59 mL/min): 0.75 mg PO QD For patients with severe renal impairment (CrCl 15 – 29 mL/min): 0.5 mg PO QD	1 mg/day

V. Product Availability

Capsules: 0.25 mg, 0.5 mg, 0.75 mg, 1 mg

VI. References

1. Talzenna Prescribing Information. New York NY: Pfizer; September 2021. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/211651s008lbl.pdf. Accessed October 4, 2021.
2. Litton JK, Rugo HS, Ettl J, et al. Talazoparib in patients with advanced breast cancer and a germline BRCA mutation. *N Engl J Med.* 2018; 379:753-763.
3. Talazoparib In: National Comprehensive Cancer Network. Breast Cancer. Version 8.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed October 4, 2021.
4. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed October 4, 2021..

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	11.27.18	02.19
No significant changes; finalized line of business to apply to HIM; removed “as detected by an FDA-approved test (e.g., BRCAAnalysis CDx)” for BRCA mutation.	04.22.19	
1Q 2020 annual review: no significant changes; added recurrent or locally advanced breast cancer to align with NCCN and FDA-approved indication; references reviewed and updated.	10.29.19	02.20
Added requirement for no prior PARP inhibitor use; added off-label dosing language.	06.23.20	08.20
1Q 2021 annual review: updated dose limits given renal impairment adjustments would exceed 1 capsule per day; added new template language regarding redirection to generic if available for oral oncology agents; references reviewed and updated; references to HIM.PHAR.21 revised to HIM.PA.154.	10.15.20	02.21
1Q 2022 annual review: no significant changes; RT4: added new strengths (0.5 mg and 0.75 mg) and removed dose optimization language for renal impairment; references reviewed and updated.	10.04.21	02.22
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less	01.20.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.23.22	

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.

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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.

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