Utilization Review Policy 176

POLICY: Oncology – Onivyde® (irinotecan liposome injection – Ipsen Biopharmaceuticals)

EFFECTIVE DATE: 1/1/2020
LAST REVISION DATE: 02/19/2025

COVERAGE CRITERIA FOR: All UCare Plans

OVERVIEW
Onivyde, a topoisomerase inhibitor, is indicated for the treatment of **metastatic pancreatic adenocarcinoma**:[1]

- In combination with fluorouracil and leucovorin in adults after disease progression following gemcitabine-based therapy.
- In combination with oxaliplatin, fluorouracil, and leucovorin for first-line treatment of adults.

Limitation of use: Onivyde is not indicated as a single agent for the treatment of patients with metastatic pancreatic adenocarcinoma.

Guidelines
The National Comprehensive Cancer Network has addressed Onivyde for the following indications:

- **Ampullary adenocarcinoma:** Clinical practice guidelines (version 2.2025 – January 10, 2025) recommend Onivyde, in combination with fluorouracil and leucovorin, for the subsequent treatment of disease progression in patients with pancreatobiliary and mixed type disease with good performance status (defined as Eastern Cooperative Oncology Group [ECOG] performance status of 0 or 1, good biliary drainage, and adequate nutritional intake) [category 2A].[3,4] In addition, Onivyde is recommended as first-line treatment of metastatic disease, as a component of NALIRIFOX (fluorouracil, leucovorin, liposomal irinotecan, and oxaliplatin).
- **Biliary tract cancers:** Clinical practice guidelines (version 6.2024 – January 10, 2025) recommend Onivyde in combination with fluorouracil and leucovorin for the subsequent treatment of unresectable, resected gross residual, or metastatic biliary tract cancers (category 2B).[3,5]
- **Pancreatic adenocarcinoma:** Clinical practice guidelines (version 2.2025 – February 3, 2025) recommend Onivyde, in combination with fluorouracil and leucovorin, for the first-line and subsequent treatment of locally advanced (category 2A), or metastatic (category 1) pancreatic adenocarcinoma in patients with ECOG performance status of 0 to 2.[2,3]

Safety
Onivyde has a Boxed Warning for neutropenia and diarrhea.[1]

POLICY STATEMENT
Prior Authorization is recommended for medical benefit coverage of Onivyde. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indications. Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Onivyde as well as the monitoring required for adverse events and long-term efficacy, approval requires Onivyde to be prescribed by or in consultation with a physician who specializes in the condition being treated.
Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA
Coverage of Onivyde is recommended in those who meet one of the following criteria:

FDA-Approved Indication

1. **Pancreatic Adenocarcinoma.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has locally advanced or metastatic disease; AND
   - **C)** Medication will be used in combination with fluorouracil and leucovorin; AND
   - **D)** Medication is prescribed by or in consultation with an oncologist.

   Dosing. Approve up to 70 mg/m^2 administered intravenously no more frequently than once every 2 weeks.

Other Uses with Supportive Evidence

2. **Ampullary Adenocarcinoma**. Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient meets ONE of the following (i or ii):
     - **i.** Medication is used as first-line treatment; OR
     - **ii.** Patient has tried at least ONE of the following chemotherapy regimens (a, b, or c):
       - **a)** Gemcitabine-based therapy; OR
       - **b)** Fluoropyrimidine-based therapy, if no prior irinotecan; OR
       - **c)** Oxaliplatin-based therapy, if no prior irinotecan; AND
   - **C)** Medication will be used in combination with fluorouracil and leucovorin; AND

D) Medication is prescribed by or in consultation with an oncologist.

Dosing. Approve up to 70 mg/m^2 administered intravenously no more frequently than once every 2 weeks.

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3. Biliary Tract Cancer. Approve for 1 year if the patient meets ALL of the following (A, B, C, D, and E):

A) Patient is ≥ 18 years of age; AND

B) Patient has ONE of the following (i, ii, or iii):

i. Gallbladder cancer; OR

ii. Extrahepatic cholangiocarcinoma; OR

iii. Intrahepatic cholangiocarcinoma; AND

C) Patient has disease progression on or after systemic therapy; AND
Note: Examples of systemic therapy include gemcitabine, cisplatin, fluorouracil, and capecitabine.

D) Medication is used in combination with fluorouracil and leucovorin; AND

E) The medication is prescribed by or in consultation with an oncologist.

Dosing. Approve up to 70 mg/m^2 administered intravenously no more frequently than once every 2 weeks.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Onivyde is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Onivyde® liposome intravenous infusion [prescribing information]. Basking Ridge, NJ: Ipsen; December 2024.
2. The NCCN Pancreatic Adenocarcinoma Clinical Practice Guidelines in Oncology (version 2.2025 – February 3, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed February 11, 2025.
3. The NCCN Drugs and Biologics Compendium. © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on February 11, 2025. Search term: irinotecan liposome.
4. The NCCN Ampullary Adenocarcinoma Clinical Practice Guidelines in Oncology (version 2.2025 – January 10, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed February 11, 2025.
5. The NCCN Biliary Tract Cancers Clinical Practice Guidelines in Oncology (version 6.2024 – January 10, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on February 11, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	04/19/2023
Early Annual Revision	**Pancreatic Adenocarcinoma:** Removed requirement that the patient has tried gemcitabine based chemotherapy or fluoropyrimidine based chemotherapy without irinotecan.	02/28/2024

UCare P&T Review	Policy reviewed and approved by UCare P&T committee. Annual review process	09/16/2024
Annual Revision	**Ampullary Adenocarcinoma:** Added medication is used first-line as new option for approval.	02/19/2025