

**Clinical Policy: Lorlatinib (Lorbrena)**

Reference Number: CP.PHAR.406

Effective Date: 03.01.19

Last Review Date: 05.25

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

**Description**

Lorlatinib (Lorbrena<sup>®</sup>) is a kinase inhibitor.

**FDA Approved Indication(s)**

Lorbrena is indicated for the treatment of adult patients with metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test.

**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<sup>®</sup> that Lorbrena is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria****A. Non-Small Cell Lung Cancer (must meet all):**

1. Diagnosis of recurrent, advanced, or metastatic NSCLC;
2. Prescribed by or in consultation with an oncologist;
3. Age  $\geq$  18 years;
4. Disease is ALK or ROS1 positive;
5. If disease is ROS1 positive, failure of Augtyro<sup>™</sup>, Rozlytrek<sup>™</sup>, Xalkori<sup>®</sup>, unless clinically significant adverse effects are experienced or all are contraindicated;  
*\*Prior authorization may be required for Augtyro, Rozlytrek, and Xalkori.*
6. Prescribed as a single agent;
7. For Lorbrena requests, member must use generic lorlatinib, 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 (i and ii):
    - i. 100 mg per day;
    - ii. 1 tablet 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. Additional NCCN Recommended Uses (off-label) (must meet all):**

1. Prescribed for one of the following diagnoses (a - f):
  - a. Anaplastic large cell lymphoma that is relapsed or refractory;
  - b. Diffuse large B-cell lymphoma that is relapsed or refractory;
  - c. Erdheim-Chester disease that is symptomatic or relapsed/refractory;
  - d. Inflammatory myofibroblastic tumor (IMT: a soft tissue sarcoma);
  - e. Uterine IMT that is advanced, recurrent, metastatic, or inoperable;
  - f. Pediatric diffuse high-grade glioma;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age meets one of the following (a or b):
  - a. For pediatric diffuse high-grade glioma: < 18 years;
  - b. For all other NCCN-recommended uses: ≥ 18 years;
4. Disease is ALK positive;
5. Prescribed as a single agent;
6. For pediatric diffuse high-grade glioma, prescribed as one of the following (a or b):
  - a. Adjuvant treatment, except diffuse midline glioma, H3 K27-altered or pontine location;
  - b. Treatment of recurrent or progressive disease, except oligodendroglioma, *IDH*-mutant and 1p/19q co-deleted or astrocytoma *IDH*-mutant;
7. For Lorbrena requests, member must use generic lorlatinib, 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 (i and ii):
    - i. 100 mg per day;
    - ii. 1 tablet per day;
  - b. Requested 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

**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 Lorbrina for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Lorbrina requests, member must use generic lorlatinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, request meets one of the following (a or b):\*
  - a. New dose does not exceed both (i and ii):
    - i. 100 mg per day;
    - ii. 1 tablet 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 policy –

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*

ALK: anaplastic lymphoma kinase

FDA: Food and Drug Administration

IMT: inflammatory myofibroblastic tumor

NCCN: National Comprehensive Cancer Network

NSCLC: non-small cell lung cancer

##### *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 and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Rozlytrek <sup>®</sup> (entrectinib)	600 mg PO QD	600 mg/day
Xalkori <sup>®</sup> (crizotinib)	250 mg PO BID	500 mg/day
Augtyro <sup>™</sup> (reprotrectinib)	160 mg PO BID	320 mg/day

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

##### *Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): concomitant use with strong CYP3A inducers
- Boxed warning(s): none reported

#### V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
ALK-positive NSCLC	100 mg PO QD	100 mg/day

#### VI. Product Availability

Tablets: 25 mg, 100 mg

#### VII. References

1. Lorbrina Prescribing Information. New York, NY: Pfizer Inc; August 2024. Available at: [www.pfizer.com](http://www.pfizer.com). Accessed January 15, 2025.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: [http://www.nccn.org/professionals/drug\\_compendium](http://www.nccn.org/professionals/drug_compendium). Accessed February 18, 2025.
3. National Comprehensive Cancer Network. Non-Small Cell Lung Cancer Version 3.2025. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/nscl.pdf](https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf). Accessed February 15, 2025.
4. Clinical Pharmacology [database online]. Tampa, FL: Elsevier, Inc. Updated periodically. Accessed February 15, 2025.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2021 annual review: RT4: updated FDA-approved indication for NSCLC removing disease progression on specific prior therapies; per NCCN Compendium which supports Lorbrina as first-line therapy in ALK positive NSCLC, removed requirement for use of prior therapies; oral oncology generic redirection language added; revised reference to HIM off-label use policy from HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	03.23.21	05.21
2Q 2022 annual review: added criterion for use as single-agent therapy for NSCLC; maximum dose corrected to “100 mg (1 tablet per day)” in criteria; Commercial approval durations revised from “Length of Benefit” to “12 months or duration of request, whichever is less”; references reviewed and updated.	04.15.22	05.22
Template changes applied to other diagnoses/indications.	09.23.22	
2Q 2023 annual review: added off-label NCCN-supported indications of diffuse large B-cell lymphoma, Erdheim-Chester disease, IMT, and uterine sarcoma; references reviewed and updated.	02.04.23	05.23
2Q 2024 annual review: added Augtyro as a failure option for ROS1-positive disease and added anaplastic large cell lymphoma indication per NCCN; condensed uterine sarcoma IMT-specific criteria; references reviewed and updated.	01.11.24	05.24
2Q 2025 annual review: removed Zykadia from list of ROS1-positive NSCLC failure agents per NCCN update; added pediatric diffuse high-grade glioma to NCCN-supported off-label indications; references reviewed and updated.	02.18.25	05.25

**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.

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