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Reviewed: 05/14/25

Revised: 06/15/25

Subject: Oral Oncology Medications

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

Position Statement | Billing/Coding | Reimbursement | Program Exceptions | Definitions

Related Guidelines | Other | References | Updates

DESCRIPTION:

The National Comprehensive Care Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®) provide recommendations for the prevention and treatment of approximately 97% of all cancers in the United States. The NCCN categories for recommendations are based on the level of clinical evidence available and the degree of agreement of a voting multidisciplinary panel of cancer experts with regard to the appropriateness of the intervention. The level of evidence depends upon the quality, quantity, and consistency of data from trials and cases. The voting panel considers the efficacy, safety, and toxicity of treatments available.

NCCN Categories for recommendations		Voting panel consensus
Category 1	Based upon high-level evidence; there is uniform NCCN consensus that the intervention is appropriate	At least 85%
Category 2A	Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate	At least 85%
Category 2B	Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate	At least 50% (but less than 85%)
Category 3	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate	At least 25%

In addition categories of evidence, some of the NCCN Guidelines include recommended levels of preference. The categories of preference are intended to guide selection of the optimal treatment when multiple options are available or to address specific clinical circumstances.

NCCN Categories of preference

Preferred intervention	Interventions that are based on superior efficacy, safety, and evidence; and, when appropriate, affordability
Other recommended intervention	Other interventions that may be somewhat less efficacious, more toxic, or based on less mature data; or significantly less affordable for similar outcomes
Useful in certain circumstances	Other interventions that may be used for select patient populations (defined with recommendation)

This medical coverage guideline (MCG) applies only to oral oncology agents that do not have an existing MCG developed by Florida Blue or a relevant Prime Therapeutics criteria document. For agents with an existing Florida Blue MCG or relevant Prime Therapeutics criteria document, refer to that MCG/document for medical necessity criteria. Additionally, **Table 1** lists specific drugs that should be reviewed using this MCG. This list is not comprehensive.

POSITION STATEMENT:

Comparative Effectiveness

The FDA has deemed the drug(s) or biological product(s) in this coverage policy to be appropriate for self-administration or administration by a caregiver (i.e., not a healthcare professional). Therefore, coverage (i.e., administration) in a provider-administered setting such as an outpatient hospital, ambulatory surgical suite, physician office, or emergency facility is not considered medically necessary.

Initiation of an oral oncology medication **meets the definition of medical necessity** when **ALL** of the following criteria are met:

I. **ONE** of the following is met:
   A. Requested oral oncology product is not included in an existing medical coverage guideline developed by Florida Blue (or relevant Prime Therapeutics criteria document)
   B. Requested product is listed in **Table 1**

II. **ONE** of the following to support clinical use is met:
   A. **ALL** of the following are met regarding FDA labeling or NCCN Compendium:
      i. **ONE** of the following (indication and usage):
         1. Member is diagnosed with a condition that is consistent with an indication listed in the product's FDA-approved prescribing information (or package insert) **AND** member meets any additional requirements listed in the "Indications and Usage" section of the FDA-approved prescribing information (or package insert)
         2. Indication **AND** usage is recognized in NCCN Drugs and Biologics Compendium as a Category 1 or 2A recommendation (**Table 2**)
      ii. **ONE** of the following (diagnostic testing¶):
         1. **ALL** of the following:
            a. The requested indication requires genetic/specific diagnostic testing per FDA labeling or NCCN Compendium for the requested agent

b. Genetic/specific diagnostic testing has been completed

c. The results of the genetic/specific diagnostic testing indicate therapy with the requested agent is appropriate – documentation must be submitted

2. The requested indication does **NOT** require specific genetic/diagnostic testing per FDA labeling or NCCN Compendium

B. Requested product is designated as an orphan drug by the FDA for the requested indication **AND** the indication is not included in the FDA labeling or the NCCN compendium as a 1 or 2A recommendation (i.e., "Designated/Approved", "Designated") (Orphan drug designations can be found at http://www.accessdata.fda.gov/scripts/opdlisting/oopd/)

C. The indication **AND** usage of the requested product is supported by the results of **TWO or more** published clinical studies – prescriber must submit full text copies of each article

NOTE:

- Case reports, posters, and abstracts (including published meeting abstracts) are not accepted as evidence to support for use.
- Clinical studies must be supportive of use for a similar patient population (e.g., indication, diagnosis, disease severity, genetic or tumor mutations) and for the intended treatment plan, including any concomitant therapy.

III. The dose does not exceed the maximum FDA-approved dose and frequency with the following exceptions:

A. Dose and frequency for indication are supported by standard reference compendia (NCCN Compendium or other compendia in **Table 3)**

B. Dose and frequency for indication are supported by the results of **TWO** or more published clinical studies – prescriber must submit full text copies of each article

NOTE: Dose ranging studies, case reports, posters, and abstracts (including published meeting abstracts) are not accepted as evidence to support use

IV. The dose will be achieved using the fewest number of capsules or tablets per day **OR** does not exceed the quantity limit (http://www.bcbsfl.com/DocumentLibrary/Providers/Content/Rx_ResponsibleQuantity.pdf)

V. If the requested agent is a brand product with a generic equivalent in the strength requested (noted in **Table 1**) **ALL** of the following are met[†]:

A. The member has tried and had intolerable adverse effects to the generic product

B. The specific intolerance(s) and rationale for using the brand must be specified

C. A completed Medwatch reporting form (FDA 3500) must be submitted- https://www.fda.gov/safety/medical-product-safety-information/forms-reporting-fda

D. A completed Naranjo Adverse Drug reaction probability scale - https://assets.guidewell.com/m/2736e82ff52fe22d/original/mcg-naranjo-algorithm.pdf

Approval duration: 6 months (For Vitrakvi, 3 months approval duration)

Continuation of an oral oncology medication **meets the definition of medical necessity** when **ALL** of the following criteria are met:

I. **ONE** of the following:

   A. Requested oral oncology product is not included in an existing medical coverage guideline developed by Florida Blue (or relevant Prime Therapeutics criteria document)

   B. Requested product is listed in **Table 1**

II. The member has been previously approved by Florida Blue or another health plan in the past 2 years for the medication, **OR** the member has previously met all indication-specific criteria for coverage

III. The dose does not exceed the maximum FDA-approved dose and frequency with the following exceptions:

   A. Dose and frequency for indication are supported by standard reference compendia (NCCN Compendium or **Table 3)**

   B. Dose and frequency for indication are supported by the results of **TWO** or more published clinical studies – prescriber must submit full text copies of each article

      NOTE: Dose ranging studies, case reports, posters, and abstracts (including published meeting abstracts) are not accepted as evidence to support use

VI. The dose will be achieved using the fewest number of capsules or tablets per day **OR** does not exceed the quantity limit (http://www.bcbsfl.com/DocumentLibrary/Providers/Content/Rx_ResponsibleQuantity.pdf)

IV. If the requested agent is a brand product with a generic equivalent in the strength requested (noted in **Table 1**) **ALL** of the following are met†:

   A. The member has tried and had intolerable adverse effects to the generic product
   B. The specific intolerance(s) and rationale for using the brand must be specified

   C. A completed Medwatch reporting form (FDA 3500) must be submitted- https://www.fda.gov/safety/medical-product-safety-information/forms-reporting-fda

   D. A completed Naranjo Adverse Drug reaction probability scale - https://assets.guidewell.com/m/2736e82ff52fe22d/original/mcg-naranjo-algorithm.pdf

Approval duration: 1 year

†Step therapy requirement does not apply if a prior health plan paid for the medication - documentation of a paid claim within the past 90 days must be submitted

Table 1

Oral oncology medications that must meet medical necessity criteria. (NOTE: This is NOT a comprehensive list of all agents that should be reviewed)
Brand (generic) Product
Afinitor (everolimus tablet)*
Afinitor Disperz (everolimus tablet for oral suspension)*
Akeega (niraparib/abiraterone acetate)
Alecensa (alectinib)

Alunbrig (brigatinib)
Augtyro (repotrectinib)
Ayvakit (avapritinib)
Balversa (erdafitinib)
Braftovi (encorafenib)
Brukinsa (zanubrutinib)
Cabometyx (cabozantinib tablets)
Calquence (acalabrutinib capsules and tablets)
Caprelsa (vandetanib)
Cometriq (cabozantinib capsules)
Copiktra (duvelisib)
Cotellic (cobimetinib)
Daurismo (glasdegib)
Erivedge (vismodegib)
Erleada (apalutamide)
Ensacove (ensartinib)
Farydak (panobinostat)
Fotivda (tivozanib)
Fruzaqla (fruquintinib)
Gavreto (pralsetinib)
Gilotrif (afatinib)
Gleevec (imatinib)*
Gomekli (mirdametinib capsules and tablets)
Hycamtin (topotecan capsules)
Ibrance (palbociclib)
Iclusig (ponatinib)
Idhifa (enasidenib)
Inlyta (axitinib)
Inqovi (decitabine;cedazuridine)
Inrebic (Fedratinib)
Iressa (gefitinib)
Itovebi (inavolisib)
Iwilfin (eflornithine hydrochloride)
Jakafi (ruxolitinib)
Jaypirca (pirtobrutinib)
Kisqali (ribociclib)
Koselugo (selumetinib)
Krazati (adagrasib)
Lazcluze (lazertinib)
Lenvima (lenvatinib)
Lonsurf (trifluridine/tipiracil)
Lorbrena (lorlatinib)
Lumakras (sotorasib)

Lynparza (olaparib)
Lytgobi (futibatinib)
Mekinist (trametinib tablets and oral solution)
Mektovi (binimetinib)
Nerlynx (neratinib)
Nexavar (sorafenib)
Nubeqa (darolutamide)
Odomzo (sonidegib)
Ogsiveo (nirogacestat)
Ojemda (tovorafenib tablet and oral suspension)
Onureg (azacitidine)
Orserdu (elacestrant)
Pemazyre (pemigatinib)
Phyrago (dasatinib)
Piqray (alpelisib)
Pomalyst (pomalidomide)
Qinlock (ripretinib)
Retevmo (selpercatinib capsule and tablets)
Revlimid (lenalidomide)
Revuforj (revumenib)
Rezlidhia (olutasidenib)
Romvimza (vimseltinib)
Rozlytrek (entrectinib)
Rubraca (rucaparib)
Rydapt (midostaurin)
Sprycel (dasatinib)
Stivarga (regorafenib)
Sutent (sunitinib)*
Tabrecta (capmatinib)
Tafinlar (dabrafenib capsules and tablets for oral suspension)
Tagrisso (osimertinib)
Talzenna (talazoparib)
Tarceva (erlotinib)*
Targretin (bexarotene capsules)*
Tazverik (tazemetostat)
Temodar (temozolomide capsules)*
Tepmetko (tepotinib)
Tibsovo (ivosidenib)
Tretinoin capsule
Truqap (capivasertib)
Truseltiq (infigratinib)
Tukysa (tucatinib)

Turalio (pexidartinib)
Tykerb (lapatinib)*
Ukoniq (umbralisib)
Vanflyta (quizartinib)
Venclexta (venetoclax)
Verzenio (abemaciclib)
Vitrakvi (larotrectinib)
Vizimpro (dacomitinib)
Voranigo (vorasidenib)
Votrient (pazopanib)*
Welireg (belzutifan)
Xalkori (crizotinib) capsules and pellets
Xospata (gilteritinib)
Xpovio (selinexor)
Xtandi (enzalutamide)
Zejula (niraparib)
Zelboraf (vemurafenib)
Zolinza (vorinostat)
Zydelig (idelalisib)
Zykadia (ceritinib)
***Generic**

Table 2

NCCN Categories of Evidence Consensus	
Category 1	Based upon high-level evidence; there is uniform NCCN consensus that the intervention is appropriate
Category 2A	Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate
Category 2B	Based upon lower-level evidence, there NCCN consensus that the intervention is appropriate
Category 3	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate

Table 3

Other compendia	
Compendium	**Covered Uses**[†]
AHFS-DI	Narrative text is supportive
Clinical Pharmacology	Narrative text is supportive
Lexicomp	Evidence rating A, B or G
Thomson Micromedex DrugDex	Meets requirements for **BOTH** of the following: • Strength of recommendation: Class I (Recommended) or IIa (Recommended, In Most Cases) • Efficacy: Class I (Effective) or IIa (Evidence Favors Efficacy)

†If covered use criteria are not met, the request should be denied. AHFS-DI, American Hospital Formulary Service Drug Information; For additional information regarding designated compendia, please refer to the "Definitions" section.

FDA Companion Diagnostics: https://www.fda.gov/medical-devices/vitro-diagnostics/list-cleared-or-approved-companion-diagnostic-devices-vitro-and-imaging-tools

For Medicare Part B and Medicare Advantage members, the reviewer shall refer to National and Local Coverage Determinations. National and Local Coverage Determinations can be found at: http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

REIMBURSEMENT INFORMATION:

Refer to section entitled **POSITION STATEMENT**.

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Part D: Florida Blue has delegated to Prime Therapeutics authority to make coverage determinations for the Medicare Part D services referenced in this guideline.

Medicare Advantage: No National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) were found at the time of the last guideline review date.

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if based on medical necessity. The process for requesting a protocol exemption can be found at Coverage Protocol Exemption Request.

DEFINITIONS:

Table 5

Lexicomp Recommendation Ratings	
A	Consistent evidence from well-performed randomized, controlled trials or overwhelming evidence of some other form (eg, results of the introduction of penicillin treatment) to support the off-label use. Further research is unlikely to change confidence in the estimate of benefit.
B	Evidence from randomized, controlled trials with important limitations (inconsistent results, methodological flaws, indirect or imprecise), or very strong evidence of some other research design. Further research (if performed) is likely to have an impact on confidence in the estimate of benefit and risk and may change the estimate.
C	Evidence from observational studies (eg, retrospective case series/reports providing significant impact on patient care), unsystematic clinical experience, or from

	potentially flawed randomized, controlled trials (eg, when limited options exist for condition). Any estimate of effect is uncertain.
G	Use has been substantiated by inclusion in at least one evidence-based or consensus-based clinical practice guideline.

Table 6

Thomson Micromedex DrugDex Recommendation Ratings: Strength of Recommendation		
Class I	Recommended	The given test or treatment has been proven to be useful, and should be performed or administered
Class IIa	Recommended, in most cases	The given test or treatment is generally considered to be useful, and is indicated in most cases.
Class IIb	Recommended in some cases	The given test or treatment may be useful, and is indicated in some, but not most, cases
Class III	Not recommended	The given test or treatment is not useful and should be avoided
Class Indeterminate	Evidence Inconclusive	

Table 7

Thomson Micromedex DrugDex Recommendation Ratings: Efficacy		
Class I	Effective	Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective
Class IIa	Evidence favors efficacy	Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy.
Class IIb	Evidence is inconclusive	Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion argues against efficacy.
Class III	Ineffective	Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is ineffective

RELATED GUIDELINES:

None

OTHER:

None

REFERENCES:

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Pharmacy Policy Committee on 05/14/25.

GUIDELINE UPDATE INFORMATION:

05/15/20	New Medical Coverage Guideline
10/01/20	Revision to guideline; consisting of adding Koselugo, Qinlock, Pemazyre, Retevmo, Tabrecta, and Tukysa to Table 1.
11/15/20	Revision to guideline; consisting of adding Gavreto, Onureg, and Inqovi to Table 1.
01/15/21	Revision to guideline; consisting of updating the position statement and adding Afinitor, Afinitor Disperz, Cabometyx, Cometriq, Gleevec, Hycamtin, Tagretin, Tarceva, Temodar, and Xeloda to Table 1.
07/01/21	Revision to guideline; consisting of adding Fotivda, Tepmetko, and Ukoniq to Table 1.
10/01/21	Revision to guideline; consisting of adding Lumakras and Truseltiq to Table 1.
01/01/22	Revision to guideline; consisting of adding Exkivity and Welireg to Table 1 and updating generic use of Sutent.
01/15/22	Revision to guideline; consisting of updating generic use of Afinitor and Afinitor Disperz.

11/15/22	Review and revision to guideline; consisting of adding Calquence tablets to Table 1.
01/01/23	Review and revision to guideline; consisting of adding Kisqali to Table 1.
04/01/23	Review and revision to guideline; consisting of adding Inrebic capsules, Rezlidhia capsules, Lytgobi tablets, and Krazati tablets to Table 1 and removal of Xeloda (capecitabine) from Table 1.
04/15/23	Review and revision to guideline; addition of Jaypirca and Orserdu tablets to Table 1.
06/15/23	Review and revision to guideline; addition of Mekinist oral solution and Tafinlar tablets for oral suspension to Table 1.
08/15/23	Revision to guideline; modified statement using fewest number of tablets or capsules to allow up to the quantity limit.
11/15/23	Review and revision to guideline; addition of Akeega tablets, Vanflyta tablets, Xalkori pellets to Table 1.
04/01/24	Review and revision to guideline; addition of Augtyro capsules, Fruzaqla capsules, Iwilfin tablets, Ogsiveo tablets, Phyrago tablets, and Truqap tablets.
10/01/24	Review and revision to guideline; addition of Ojemda tablets and oral suspension to Table 1. Retevmo tablets were added and a step through generic pazopanib was included for Votrient.
11/15/24	Review and revision to guideline; addition of Lazcluze and Voranigo tablets to Table 1.
04/01/25	Review and revision to guideline; addition of Revuforj tablets, Itovebi tablets, and Ensacove capsules to Table 1.
06/15/25	Review and revision to guideline; addition of Gomekli capsules and tablets and Romvimza capsules to Table 1.