PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Oral – Neurotrophic Tyrosine Receptor Kinase Gene Fusion) – Augtyro Prior Authorization Policy
- Augtyro™ (repotrectinib capsules – Bristol-Myers Squibb Company)

REVIEW DATE: 07/23/2025

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Augtyro, a kinase inhibitor, is indicated for the following uses[1]:
- **Non-small cell lung cancer (NSCLC),** for the treatment of locally advanced or metastatic *ROS1*-positive disease in adults.
- **Solid tumors,** in adults and pediatric patients ≥ 12 years of age:
  - For the treatment of neurotrophic tyrosine receptor kinase (*NTRK*) gene fusion-positive tumor; AND
  - For the treatment of locally advanced or metastatic disease or where surgical resection is likely to result in severe morbidity; AND
  - For disease that have progressed following treatment or have no satisfactory alternative therapy.

The NTRK gene fusion-positive solid tumor indication is approved under accelerated approval based on overall response rate and duration of response. Continued

approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

Guidelines

Augtyro is addressed in the following National Comprehensive Cancer Network (NCCN) guidelines:

- **NSCLC**. Guidelines(version 7.2025 – July10, 2025) recommend Augtyro, Ibtrozi™ (taletrectinib capsules), Rozlytrek® (entrectinib capsules and oral pellets), and Xalkori® (crizotinib capsules) as "Preferred" first-line treatment options (all category 2A) for patients with *ROS1* rearrangement-positive NSCLC.[2] NCCN notes that Ibtrozi, Rozlytrek, or Augtyro may be better for patients with brain metastases. For subsequent therapy, Ibtrozi (if not previously given), Augtyro (if not previously given) or Lorbrena® (lorlatinib tablets) are recommended (all category 2A). For symptomatic progression to the brain, Ibtrozi, Augtyro, or Lorbrena (all "Preferred"), or Rozlytrek (useful in certain circumstances, if previously treated with Xalkori), or clinical trial is recommended. Augtyro or Ibtrozi is noted as an option for resistant mutations, such as *ROS1* G2032R. Augtyro is also recommended as "Preferred" first-line therapy for NTRK1/2/3 gene fusion. It is also recommended for subsequent therapy. Both are category 2A recommendations.
- **Solid tumors.** The NCCN Drugs and Biologics Compendium notes the use of Augtyro for *NTRK* gene fusion-positive tumors associated with the following cancers[3]: ampullary adenocarcinoma, biliary tract cancers, breast cancer, central nervous system cancers (e.g., glioma, glioblastoma, brain metastases), cervical cancer, colon cancer, esophageal and esophagogastric junction cancers, gastric cancer, gastrointestinal stromal tumors, head and neck cancers (e.g., salivary gland tumors), hepatocellular carcinoma, histiocytic neoplasms, neuroendocrine and adrenal tumors, NSCLC, occult primary, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, pancreatic cancer, rectal cancer, small bowel adenocarcinoma, soft tissue sarcomas, thyroid carcinoma, uterine neoplasms, vaginal cancer, and vulvar cancer. Augtyro is a category 2A recommendation for most of these cancers. Augtyro is recommended for use as a first-line and/or second-line treatment option for these cancers.
- **Pediatric Central Nervous System Cancers.** Guidelines (version 2.2025 – January 17, 2025) recommend Augtyro as adjuvant therapy and for recurrent or progressive disease (category 2A for both), for *NTRK* fusion-positive pediatric diffuse high-grade gliomas.[4]

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Augtyro. All approvals are provided for the duration noted below.

- **Augtyro™ (repotrectinib capsules – Bristol-Myers Squibb Company)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. **Non-Small Cell Lung Cancer.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
   Note: If the patient has non-small cell lung cancer with neurotrophic receptor tyrosine kinase (*NTRK*) gene fusion, see **Solid Tumors** indication.
   A) Patient is ≥ 18 years of age; AND
   B) Patient has locally advanced or metastatic disease; AND
   C) Patient has *ROS1*-positive non-small cell lung cancer; AND
   D) The mutation was detected by an approved test.

2. **Solid Tumors.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   Note: Examples of solid tumors include breast cancer, cholangiocarcinoma, colorectal cancer, esophageal cancer, glioblastoma, head/neck cancer, non-small cell lung cancer (*NTRK* gene fusion-positive), peripheral nerve sheath tumor, salivary gland tumor, soft tissue sarcoma, thyroid cancer.
   A) Patient is ≥ 12 years of age; AND
   B) The tumor is positive for neurotrophic tyrosine receptor kinase (*NTRK*) gene fusion; AND
   C) Patient meets ONE of the following (i or ii):
      i. The tumor is locally advanced or metastatic; OR
      ii. Surgical resection of tumor will likely result in severe morbidity.

Other Uses with Supportive Evidence

3. **Pediatric Diffuse High-Grade Gliomas.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   A) Patient is < 18 years of age; AND
   B) The tumor is positive for neurotrophic receptor tyrosine kinase (*NTRK*) gene fusion; AND
   C) Patient meets ONE of the following (i or ii):
      i. The medication is used as adjuvant therapy; OR
      ii. The medication is used for recurrent or progressive disease.

CONDITIONS NOT COVERED

- **Augtyro™ (repotrectinib capsules – Bristol-Myers Squibb Company)**

is(are) considered not medically necessary for ANY other use(s); criteria will be updated as new published data are available.

REFERENCES

1. Augtyro™ capsules [prescribing information]. Princeton, NJ: Bristol-Myers Squibb Company; June 2024.
2. The NCCN Non-Small Cell Lung Cancer Clinical Practice Guidelines in Oncology (version 7.2025 – July 10, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on July 21, 2025.
3. The NCCN Drugs & Biologics Compendium. © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on July 21, 2025. Search term: repotrectinib.
4. The NCCN Pediatric Central Nervous System Cancers Clinical Practice Guidelines in Oncology (version 2.2025 – January 17, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on July 21, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy		11/29/2023
Update	01/05/2024: Updated guidelines section addressing Augtyro.	--
Early Annual Revision	Solid Tumors: Added new FDA-approval condition and criteria	07/03/2024
Update	04/20/2025: The policy name was changed from "Oncology – Augtyro PA Policy" to "Oncology (Oral – Neurotrophic Tyrosine Receptor Kinase Gene Fusion) – Augtyro PA Policy".	N/A
Annual Revision	**Non-Small Cell Lung Cancer:** Added Note referring to Solid Tumors indication for NTRK gene fusion non-small cell lung cancer. Solid Tumors: Deleted criteria that disease has progressed following treatment or there are no satisfactory alternative therapies. **Pediatric Diffuse High-Grade Gliomas:** This condition and criteria for approval were added to the policy under "Other Uses with Supportive Evidence."	07/23/2025

N/A – Not applicable.