

**Clinical Policy: Pirtobrutinib (Jaypirca)**

Reference Number: CP.PHAR.620

Effective Date: 06.01.23

Last Review Date: 05.24

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

**Description**

Pirtobrutinib (Jaypirca<sup>®</sup>) is a Bruton tyrosine kinase (BTK) inhibitor.

**FDA Approved Indication(s)**

Jaypirca is indicated for the treatment of adult patients with:

- Relapsed or refractory mantle cell lymphoma (MCL) after at least two lines of systemic therapy, including a BTK inhibitor.\*
- Chronic lymphocytic leukemia or small lymphocytic lymphoma (CLL/SLL) who have received at least two prior lines of therapy, including a BTK inhibitor and a B-cell lymphoma 2 inhibitor (BCL2i).\*

*\*This indication is approved under accelerated approval based on response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.*

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

**I. Initial Approval Criteria****A. Chronic Lymphocytic Leukemia, Small Lymphocytic Lymphoma (must meet all):**

1. Diagnosis of CLL or SLL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age  $\geq$  18 years;
4. For Jaypirca requests, member must use pirtobrutinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. One of the following (a, b, or c):
  - a. Member has received  $\geq$  2 prior lines of therapy (*see Appendix B for examples*) that include both of the following (i and ii):
    - i. One BTK inhibitor (e.g., Brukinsa<sup>®</sup>, Calquence<sup>®</sup>, Imbruvica<sup>®</sup>);
    - ii. One BCL2i (e.g., Venclexta<sup>®</sup>);

*\*Prior authorization may be required.*

- b. Member has received  $\geq$  1 prior line of therapy (*see Appendix B for examples*) and has resistance or intolerance to prior covalent BTK inhibitor therapy (e.g., Brukinsa, Calquence, Imbruvica) [off-label];

- c. Member has histologic (Richter's) transformation to diffuse large B-cell lymphoma with one of the following (i or ii) [off-label]:
  - i. Member has del(17p)/TP53 mutation;
  - ii. Member is chemotherapy refractory or unable to receive chemoimmunotherapy;
6. Jaypirca is prescribed as a single agent;
7. Request meets one of the following (a or b):\*
  - a. Dose does not exceed (i and ii):
    - i. 200 mg per day;
    - ii. 2 tablets per day;
  - b. Request meets both of the following (i and ii):
    - i. Dose does not exceed both of the following (1 and 2):
      - 1) 300 mg per day;
      - 2) 3 tablets per day;
    - ii. Prescriber attestation of member's inability to avoid concomitant use of CYP3A inducer (e.g., carbamazepine, rifampin, ritonavir, St. John's wort);
  - c. 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. Mantle Cell Lymphoma (must meet all):**

1. Diagnosis of MCL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age  $\geq$  18 years;
4. For Jaypirca requests, member must use pirtobrutinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. Member has received  $\geq$  2 prior lines of therapy\* (*see Appendix B*);  
*\*Prior authorization may be required*
6. Member has received prior treatment with a BTK inhibitor (e.g., Imbruvica, Brukinsa, Calquence);
7. Request meets one of the following (a or b):\*
  - a. Dose does not exceed (i and ii):
    - i. 200 mg per day;
    - ii. 2 tablets per day;
  - b. Request meets both of the following (i and ii):
    - i. Dose does not exceed both of the following (1 and 2):
      - 1) 300 mg per day;
      - 2) 3 tablets per day;
    - ii. Prescriber attestation of member's inability to avoid concomitant use of CYP3A inducer (e.g., carbamazepine, rifampin, ritonavir, St. John's wort);
  - c. 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 Jaypirca for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Jaypirca requests, member must use pirtobrutinib, 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 (i and ii):
    - i. 200 mg per day;
    - ii. 2 tablets per day;
  - b. Both of the following (i and ii):
    - i. New dose does not exceed both of the following (1 and 2):
      - 1) 300 mg per day;
      - 2) 3 tablets per day;
    - ii. Prescriber attestation of member's inability to avoid concomitant use of CYP3A inducer (e.g., carbamazepine, rifampin, ritonavir, St. John's wort);
  - c. 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 policies – 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*

BCL2i: B-cell lymphoma 2 inhibitor	MCL: mantle cell lymphoma
BTK: Bruton tyrosine kinase	NCCN: National Comprehensive Cancer Network
CLL: chronic lymphocytic leukemia	SLL: small lymphocytic lymphoma
FDA: Food and Drug Administration	

*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 for all relevant lines of business and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<b>First-Line Treatment Regimens for MCL</b>		
CALGB (rituximab + methotrexate + cyclophosphamide, doxorubicin, vincristine, prednisone; etoposide, cytarabine, rituximab; carmustine, etoposide, cyclophosphamide/autologous stem cell rescue; rituximab)	Varies	Varies
HyperCVAD (cyclophosphamide, vincristine, doxorubicin, dexamethasone/methotrexate/ cytarabine) + rituximab	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
NORDIC (rituximab + cyclophosphamide, vincristine, doxorubicin, prednisone/rituximab + cytarabine)	Varies	Varies
TRAIANGLE regimen: RCHOP + RDHAP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone, ibrutinib)/(rituximab, dexamethasone, cytarabine) + platinum (carboplatin, cisplatin, or oxaliplatin)	Varies	Varies
LyMA regimen: RDHAP (rituximab, dexamethasone, cytarabine) + platinum (cisplatin, oxaliplatin, or carboplatin)	Varies	Varies
RCHOP/RICE (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone)/(rituximab, ifosfamide, carboplatin, etoposide)	Varies	Varies
bendamustine (Bendeka <sup>®</sup> ) + Rituxan <sup>®</sup> (rituximab)	Varies	Varies
VR-CAP (bortezomib, rituximab, cyclophosphamide, doxorubicin, prednisone)	Varies	Varies
CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) + Rituxan <sup>®</sup> (rituximab)	Varies	Varies
lenalidomide (Revlimid <sup>®</sup> ) + Rituxan <sup>®</sup> (rituximab)	Varies	Varies
RBAC500 (rituximab, bendamustine, cytarabine)		
Calquence (acalabrutinib) + Rituxan (rituximab)	Varies	Varies
<b>Second-Line and Subsequent Therapy for MCL</b>		
BTK inhibitors (Calquence, Brukinsa)	Varies	Varies
bendamustine (Bendeka)	Varies	Varies
bendamustine (Bendeka) + bortezomib (Velcade) + rituximab	Varies	Varies
bortezomib (Velcade) ± rituximab	Varies	Varies
DHA (dexamethasone, cytarabine) + platinum (carboplatin, cisplatin, or oxaliplatin) + rituximab		
Imbruvica (ibrutinib) + Venclexta (venetoclax)	Varies	Varies
Imbruvica ± rituximab	Varies	Varies
lenalidomide (Revlimid) + rituximab	Varies	Varies
RBAC500 (rituximab, bendamustine, cytarabine)	Varies	Varies
Venclexta <sup>®</sup> (venetoclax)	Varies	Varies
<b>CLL/SLL</b>		
<i>Examples of first-line, second-line and subsequent therapies:</i>	Varies	Varies
<ul style="list-style-type: none"> <li>• FCR (fludarabine, cyclophosphamide, rituximab)</li> <li>• HDMP (high-dose methylprednisolone) + rituximab</li> </ul> Single-agent examples: Imbruvica <sup>®</sup> (ibrutinib); Brukinsa (zanabrutinib), Campath <sup>®</sup> (alemtuzumab) ± rituximab; Gazyva; Copiktra <sup>®</sup> (duvelisib); Calquence (acalabrutinib) ± Gazyva; Venclexta + Gazyva; Venclexta + rituximab; Revlimid <sup>®</sup> (lenalidomide) ± rituximab; Arzerra <sup>®</sup> (ofatumumab) ± FC (fludarabine, cyclophosphamide); Leukeran <sup>®</sup> (chlorambucil) + rituximab; Zydelig <sup>®</sup> (idelalisib) ± rituximab, bendamustine +		

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
anti-CD20 monoclonal antibody, Gazyva ± Leukeran <sup>®</sup> (chlorambucil)		

*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*  
None reported

#### V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MCL, CLL, SLL	200 mg PO QD	200 mg/day

#### VI. Product Availability

Tablets: 50 mg, 100 mg

#### VII. References

- Jaypirca Prescribing Information. Indianapolis, IN; Lily USA, LLC: December 2023. Available at: [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2023/216059s0011bl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/216059s0011bl.pdf). Accessed February 12, 2023.
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- National Comprehensive Cancer Network. B-cell Lymphomas Version 1.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/b-cell.pdf](https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf). Accessed February 14, 2024.
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- Mato AR, Woyach JA, Brown JR, et al. Pirtobrutinib after a Covalent BTK Inhibitor in Chronic Lymphocytic Leukemia. *N Engl J Med*. 2023 July; 389:33-44.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	02.07.23	05.23
RT4: added new indication for CLL and SLL per updated prescribing information and NCCN supported off-label uses.	12.07.23	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2024 annual review: for all indications, added maximum dose criteria for concomitant use with CYP3A inducers; updated Appendix B for therapeutic alternatives per NCCN; references reviewed and updated.	02.12.24	05.24

**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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