Medical Oncology Program

Cancer Treatment Pathways

EFFECTIVE AUGUST 1, 2017
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TABLE OF CONTENTS

Contents

AIM Medical Oncology Program 3
Bladder Cancer (Urothelial) Pathways 4
Breast Cancer Pathways: Neoadjuvant 7
Breast Cancer Pathways: Adjuvant 12
Breast Cancer Pathways: Advanced/Metastatic Disease 16
Breast Cancer Pathways: Endocrine Therapy for Recurrent or Metastatic Disease 22
Chronic Myelogenous Leukemia (CML) Pathways 26
Colorectal Cancer Pathways 30
Gastric, Esophageal, and Gastroesophageal Junction Cancer (Adenocarcinoma) Pathways 36
Head and Neck Cancer Pathways 40
Hodgkin Lymphoma Pathways 43
Kidney Cancer (Renal Cell Carcinoma) Pathways 46
Lung Cancer: Non-Small Cell Lung Cancer (NSCLC) Pathways 49
Lung Cancer: Small Cell Lung Cancer Pathways 57
Melanoma Pathways: Metastatic Melanoma 60
Myeloma Pathways: Multiple Myeloma 64
NHL: Chronic Lymphocytic Leukemia (CLL)/ Small Lymphocytic Lymphoma (SLL) Pathways 71
NHL: Diffuse Large B-Cell Lymphoma Pathways 75
NHL: Follicular and Marginal Zone Lymphoma Pathways 79
NHL: Mantle Cell Lymphoma Pathways 83
Ovarian Cancer (Epithelial) Pathways 86
Pancreatic Cancer (Adenocarcinoma) Pathways 90
Prostate Cancer (Adenocarcinoma) Pathways 94
Testicular (Germ Cell) Cancer Pathways 98
Uterine (Endometrial) Cancer Pathways 101

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Effective August 1, 2017
AIM Medical Oncology Program

The goal of the AIM Oncology program is to help provide access to quality and affordable cancer care. A key component of the program is AIM Cancer Treatment Pathways.

AIM Pathways are developed using a rigorous process of evidence-based medicine. Pathways differ from clinical practice guidelines in that the objective of a Pathway is to identify a subset of regimens supported by clinical evidence and practice guidelines with the goal of further reducing unwarranted variation in care and cost. Pathways are selected based on: clinical benefit (efficacy), safety/side effects (especially those leading to hospitalizations & impacting quality of life), strength of national guideline recommendations, and cost of regimens. AIM Pathways are intended to support the use of quality cancer care.

Pathways are not available for every medical condition, but are intended to be applicable for individuals with the most common cancer types. Selecting the best cancer treatment depends upon a number of factors – the type of cancer, the stage, the biomarkers or specific genetic profile of the cancer, and unique aspects of each individual’s medical condition. Given the complexity of cancer and all of the unique individual circumstances, it would not be possible to have a Pathway option available for every specific situation. The treating oncologist will determine if, in his/her medical opinion, an AIM Pathway treatment regimen is the best option for a patient or whether, given his or her unique circumstances, another treatment regimen will be a better choice.

It is important to note that, for some health plans, we will review requested services in accordance with client medical policies and clinical guidelines. If a request is received from a provider that is not an AIM Pathway regimen, it may be reviewed and may be authorized if it is determined to be medically necessary pursuant to medical policies and clinical guidelines.

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# Bladder Cancer (Urothelial) Pathways

<table>
<thead>
<tr>
<th>Neoadjuvant Therapy</th>
<th>Clinical Stage II, III, or IV without evidence of metastases (cT2, cT3, cT4a, cT4b, M0)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMV</strong></td>
<td>cisplatin, methotrexate, and vinblastine 3 cycles[^5]</td>
</tr>
<tr>
<td>Gemcitabine (Gemzar) and cisplatin 4 cycles[^2]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adjuvant Therapy</th>
<th>Stage I or II after TURBT* or following resection of recurrent or persistent disease</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BCG</strong></td>
<td>bacillus calmette-guerin, intravesical[^20-24]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metastatic Disease</th>
<th>First line therapy (1st line)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gemcitabine (Gemzar) and cisplatin[^6,17,18]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metastatic Disease</th>
<th>Second line therapy (2nd line)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gemcitabine (Gemzar)[^9]</td>
<td></td>
</tr>
<tr>
<td>Paclitaxel[^14]</td>
<td></td>
</tr>
</tbody>
</table>

*[^TURBT]: Transurethral Resection of Bladder Tumor
[^1] In the setting of recurrent/metastatic disease, a substitution of carboplatin for cisplatin will be considered a Pathway option

---

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BLADDER CANCER (UROTHELIAL) REFERENCES


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NCCN Clinical Practice Guidelines


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# Breast Cancer Pathways: Neoadjuvant

<table>
<thead>
<tr>
<th>Neoadjuvant Therapy</th>
<th>HER2 Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC → weekly T: doxorubicin (Adriamycin) and cyclophosphamide (every 3 weeks) followed by weekly paclitaxel⁸,³³,⁴²,⁶⁰</td>
<td></td>
</tr>
<tr>
<td>ddAC → weekly T: dose dense doxorubicin (Adriamycin) and cyclophosphamide followed by weekly paclitaxel⁸,¹¹,¹²,³⁹</td>
<td></td>
</tr>
<tr>
<td>TC: docetaxel (Taxotere) and cyclophosphamide¹⁰,⁴³</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neoadjuvant Therapy</th>
<th>HER2 Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC → TH: doxorubicin (Adriamycin) and cyclophosphamide followed by paclitaxel and trastuzumab (Herceptin)¹,¹⁴,²³,²⁴,²⁶</td>
<td></td>
</tr>
<tr>
<td>TCH: docetaxel (Taxotere), carboplatin, and trastuzumab (Herceptin)²⁵,⁴⁹</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neoadjuvant Therapy</th>
<th>HER2 Positive</th>
<th>Hormone receptor (ER/PR) negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCH+P: docetaxel (Taxotere), carboplatin, trastuzumab (Herceptin), and pertuzumab (Perjeta)⁵⁰,⁵¹,⁵⁴,⁵⁵,⁵⁷</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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BREAST CANCER NEOADJUVANT REFERENCES


15. Martin M, Villar A, GEICAM Group (Spanish Breast Cancer Research Group), Spain, et al. Doxorubicin in combination with fluorouracil and cyclophosphamide (i.e. FAC regimen, day 1, 21) versus methotrexate in combination with fluorouracil and cyclophosphamide (i.e. CMF regimen, day 1, 21) as adjuvant chemotherapy for operable breast cancer: a study by the GEICAM group. Ann Oncol. 2003 Jun;14(6):833-842.


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Effective August 1, 2017


53 Briefing Book: Perjeta (pertuzumab) prepared for Oncology Drugs Advisory Committee Meeting, San Francisco: Genentech, Inc. August 9, 2013.

54 FDA Briefing Document for sBLA 125409/51, Pertuzumab (PERJETA®). Oncologic Drugs Advisory Committee Meeting, September 12, 2013.


58 Piccart-Gebhart MJ, Holmes AP, Baselga J, et al. First results from the phase III ALTTO trial (BIG 2-06; NCCTG[Alliance] NO63D) comparing one year of anti-HER2 therapy with lapatinib (L), trastuzumab (T), their sequence (T→L), or their combination (T+L) in the adjuvant treatment of HER2-positive early breast cancer (EBC). J Clin Oncol. 2014; 32(55):LBA4.


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63 Gianni L, Pienkowski T, Im YH, et al. 5-year analysis of neoadjuvant pertuzumab and trastuzumab in patients with locally advanced, inflammatory, or early-stage HER2-positive breast cancer (NeoSphere): a multicentre, open-label, phase 2 randomised trial. The Lancet Oncology. 2016;17(6):791-800. Epub 2016/05/18. PMID: 27179402


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Breast Cancer Pathways: Adjuvant

**Adjuvant Therapy | HER2 Negative**

- **AC → weekly T**: doxorubicin (Adriamycin) and cyclophosphamide (every 3 weeks) followed by weekly paclitaxel[^8,9,11,33]
- **ddAC → weekly T**: dose dense doxorubicin (Adriamycin) and cyclophosphamide followed by weekly paclitaxel[^8,9,11,12,60]
- **TC**: docetaxel (Taxotere) and cyclophosphamide[^10,19]

**Adjuvant Therapy | HER2 Positive**

- **AC → TH**: doxorubicin (Adriamycin) and cyclophosphamide followed by paclitaxel and trastuzumab (Herceptin)^[23,26]
- **TCH**: docetaxel (Taxotere), carboplatin, and trastuzumab (Herceptin)^[25,26]
- **TH**: paclitaxel and trastuzumab (Herceptin)^[34] **(Pathway for stage I HER2 positive breast cancer only)**

*Adjuvant chemotherapy pathways do NOT apply to individuals with Hormone-Receptor positive, lymph node negative, OncotypeDX™ LOW risk score

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BREAST CANCER ADJUVANT REFERENCES


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Effective August 1, 2017
The text in the image is a paragraph from a document, which includes a reference to effective August 1, 2017. The document appears to discuss medical policies and guidelines, specifically mentioning coverage criteria. It mentions the consultation of health plan medical policy/clinical guidelines and notes that pathway lists are solely for the purpose of eligibility for enhanced reimbursement and are independent of specific health plan medical policy coverage criteria. The document also references several studies and guidelines, including NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Breast Cancer (Version 3.2015) and other studies on various aspects of breast cancer treatment, such as chemotherapy, trastuzumab, and other related treatments.
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# Breast Cancer Pathways: Advanced/Metastatic Disease

## Metastatic disease | HER2 Negative | First and subsequent lines of therapy (1st line +)

- Capecitabine (Xeloda)\(^4\,24-26,28,60,65\)
- Doxorubicin (Adriamycin)\(^4\,5,9,65\)
- Gemcitabine (Gemzar)\(^14,60\)
- Paclitaxel\(^18\,20,65\)
- Vinorelbine (Navelbine)\(^15-17,65\)

## Metastatic disease | HER2 Positive | First line of therapy (1st line)

- Capecitabine (Xeloda) and trastuzumab (Herceptin)\(^40-43\)
- Gemcitabine (Gemzar) and trastuzumab (Herceptin)\(^44,45\)
- Paclitaxel and trastuzumab (Herceptin)\(^35,36\)
- Pertuzumab (Perjeta), trastuzumab (Herceptin), and docetaxel (Taxotere)\(^32,33,35\)
- Pertuzumab (Perjeta), trastuzumab (Herceptin), and paclitaxel\(^34\)
- Vinorelbine (Navelbine) and trastuzumab (Herceptin)\(^46,47\)

## Metastatic disease | HER2 Positive | Second and subsequent lines of therapy (2nd line +)

- Ado-trastuzumab emtansine (Kadcyla)\(^59,61,62\)
- Capecitabine (Xeloda) and lapatinib (Tykerb)\(^51,52\)
- Capecitabine (Xeloda) and trastuzumab (Herceptin)\(^40-43\)
- Gemcitabine (Gemzar) and trastuzumab (Herceptin)\(^44,45\)
- Paclitaxel and trastuzumab (Herceptin)\(^35,36\)
- Pertuzumab (Perjeta), trastuzumab (Herceptin), and docetaxel (Taxotere)\(^32,33,35,82\)
- Pertuzumab (Perjeta), trastuzumab (Herceptin), and paclitaxel\(^34\)
- Trastuzumab (Herceptin) and lapatinib (Tykerb)\(^49,50\)
- Trastuzumab (Herceptin) monotherapy\(^37,48\)
- Vinorelbine (Navelbine) and trastuzumab (Herceptin)\(^46,47\)

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BREAST CANCER ADVANCED/METASTATIC REFERENCES


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## Breast Cancer Pathways:
### Endocrine Therapy for Recurrent or Metastatic Disease

### First line therapy (1st line) | Recurrent or Metastatic Disease | Hormone receptor positive

- Anastrozole (Arimidex)*1,6,7,10,11,22,33
- Fulvestrant, (Faslodex) high dose*5,7,22,26,33,42
- Letrozole (Femara)*3,12,14,38
- Letrozole (Femara) and palbociclib (Ibrance)*40
- Tamoxifen†12,26

### Second and subsequent lines of therapy (2nd line +) | Recurrent or Metastatic Disease | Hormone receptor positive

- Anastrozole (Arimidex)*1,6,7,10,11,22,33
- Exemestane (Aromasin)*4,20,21,39
- Fulvestrant (Faslodex) high dose*
- Fulvestrant (Faslodex) and palbociclib (Ibrance)*40
- Letrozole (Femara)*3,12,14,38
- Tamoxifen†12,26

### First and subsequent lines of therapy (1st line +) | Recurrent or Metastatic Disease | Hormone receptor positive | HER2 positive

- Anastrozole (Arimidex) and trastuzumab (Herceptin)*46
- Letrozole (Femara) and trastuzumab (Herceptin)*49

* With ovarian suppression for premenopausal individuals. Ovarian suppression utilizes LHRH agonists given as monthly injections. 3-month depot dosing does not reliably suppress estrogen levels.

† Tamoxifen is considered Pathway for premenopausal individuals with or without ovarian suppression

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BREAST CANCER ENDOCRINE THERAPY FOR RECURRENT OR METASTATIC DISEASE REFERENCES


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# Chronic Myelogenous Leukemia (CML) Pathways

## First line of therapy (1st line)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dasatinib* (Sprycel)</td>
<td>for intermediate or high risk disease[^1-30,37-39]</td>
</tr>
<tr>
<td>Imatinib (Gleevec)</td>
<td><img src="image_url" alt="Image" /></td>
</tr>
<tr>
<td>Nilotinib* (Tasigna)</td>
<td>for intermediate or high risk disease[^6-8,31,32]</td>
</tr>
</tbody>
</table>

## Second line of therapy (2nd line) | Following treatment failure, suboptimal response†, or intolerance to first line therapy

<table>
<thead>
<tr>
<th>Drug</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bosutinib (Bosulif)</td>
<td><img src="image_url" alt="Image" /></td>
</tr>
<tr>
<td>Dasatinib (Sprycel)</td>
<td><img src="image_url" alt="Image" /></td>
</tr>
<tr>
<td>Nilotinib (Tasigna)</td>
<td><img src="image_url" alt="Image" /></td>
</tr>
<tr>
<td>Ponatinib‡ (Iclusig)</td>
<td><img src="image_url" alt="Image" /></td>
</tr>
</tbody>
</table>

## Third line of therapy (3rd line)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ponatinib (Iclusig)</td>
<td><img src="image_url" alt="Image" /></td>
</tr>
</tbody>
</table>

* For patients with intermediate or high risk disease based on Sokal or Hasford Score:
  - Sokal: Intermediate Risk=0.8-1.2; High Risk>1.2
  - Hasford: Intermediate Risk=781-1480; High Risk>1480

† Defined as lack of complete hematologic response or BCR-ABL1 transcripts > 10% (IS) or lack of partial cytogenetic response on bone marrow cytogenetics.

‡ Pathway option for second line therapy only after failure, suboptimal response, or intolerance of a second generation TKI has been used in the first line setting, or T315I mutation has been identified.

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CHRONIC MYELOGENOUS LEUKEMIA (CML) REFERENCES


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Colorectal Cancer Pathways

**Adjuvant therapy***

Capecitabine (Xeloda)\(^{52,69}\)

**FOLFOX:** fluorouracil (5-FU), leucovorin, and oxaliplatin \(^{7,8,50,51,60,69}\).

**FULV:** fluorouracil (5FU) and leucovorin\(^{1,4,7,49,52,69}\).

**Metastatic disease | RAS Wild Type (WT) or Mutant (MT) † | First or second lines of therapy (1st or 2nd line)**

Capecitabine (Xeloda)\(^{27}\)

**FOLFIRI:** fluorouracil (5FU), leucovorin, and irinotecan (Camptosar)\(^{18,23,30,32,34}\).

**FOLFIRI + bevacizumab:** fluorouracil (5FU), leucovorin, and irinotecan (Camptosar) with bevacizumab (Avastin)\(^{21,23,31,36,44,45,58}\).

**FOLFOX:** fluorouracil (5FU), leucovorin, and oxaliplatin \(^{24,26,28,30,34}\).

**FOLFOX + bevacizumab:** fluorouracil (5FU), leucovorin, oxaliplatin, with bevacizumab (Avastin)\(^{25,26,28,33,44,45,70}\).

**FOLFIRI + bevacizumab:** fluorouracil (5FU), leucovorin, oxaliplatin, and irinotecan (Camptosar) with bevacizumab (Avastin)\(^{25,26,28,33,44,45,70}\).

**FULV:** fluorouracil (5FU) and leucovorin\(^{22,27,35}\).

**FULV:** fluorouracil (5FU) and leucovorin with bevacizumab (Avastin)\(^{22,35}\).

**Metastatic disease | RAS Wild Type (WT) | First or second lines of therapy (1st or 2nd line)**

**FOLFIRI + panitumumab:** fluorouracil (5FU), leucovorin, and irinotecan (Camptosar) with panitumumab (Vectibix)\(^{11,62}\).

**FOLFOX + panitumumab:** fluorouracil (5-FU), leucovorin, and oxaliplatin with panitumumab (Vectibix)\(^{12,53,59}\).

**Irinotecan (Camptosar) and panitumumab (Vectibix)**\(^{47}\).

**Metastatic disease | RAS Wild Type (WT) | Third or subsequent lines of therapy (3rd line+)**

Panitumumab (Vectibix) monotherapy\(^{13,61,56}\).

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* Adjuvant Pathways do not apply to stage II MSI-H (microsatellite instability-high) disease.

† Exon 2 KRAS, non-exon 2 KRAS, and NRAS mutations; testing recommended for all patients with metastatic disease.

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COLORECTAL CANCER REFERENCES


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Gastric, Esophageal, and Gastroesophageal Junction Cancer (Adenocarcinoma) Pathways

<table>
<thead>
<tr>
<th>Pathway Description</th>
<th>Primary therapy</th>
<th>Recurrent/metastatic or locally advanced/inoperable disease</th>
<th>HER2 status</th>
<th>Line of therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>**Primary therapy</td>
<td>Resectable and unresectable disease**</td>
<td>Cisplatin and fluorouracil (5FU)&lt;sup&gt;3,4&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fluorouracil (5FU) and cisplatin with concurrent radiation therapy (RT)&lt;sup&gt;35&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paclitaxel and carboplatin with concurrent RT&lt;sup&gt;3&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Post-operative treatment</strong></td>
<td></td>
<td>Fluorouracil (5FU) and leucovorin with concurrent RT&lt;sup&gt;38&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Recurrent/metastatic or locally advanced/inoperable disease</td>
<td>HER2 Negative</td>
<td>First line of therapy (1&lt;sup&gt;st&lt;/sup&gt; line)**</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cisplatin and fluorouracil (5FU)&lt;sup&gt;15,19,21,26&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fluorouracil (5FU) and irinotecan (Camptosar)&lt;sup&gt;25,26&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>FLO / FOLFOX</strong>: fluorouracil (5FU), leucovorin, and oxaliplatin&lt;sup&gt;27&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>FLP</strong>: fluorouracil (5FU), leucovorin, and cisplatin&lt;sup&gt;27&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Recurrent/metastatic or locally advanced/inoperable disease</td>
<td>HER2 Positive</td>
<td>First line of therapy (1&lt;sup&gt;st&lt;/sup&gt; line)**</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cisplatin, fluorouracil (5FU), and trastuzumab (Herceptin)&lt;sup&gt;15&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Recurrent/metastatic or locally advanced/inoperable disease</td>
<td>Second line of therapy (2&lt;sup&gt;nd&lt;/sup&gt; line)**</td>
<td>Irinotecan (Camptosar)&lt;sup&gt;24,29&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paclitaxel&lt;sup&gt;33&lt;/sup&gt;</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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Effective August 1, 2017
GASTRIC, ESOPHAGEAL, AND GASTROESOPHAGEAL JUNCTION (ADENOCARCINOMA) CANCERS REFERENCES


Note: Pathway lists are solely for the purpose of eligibility for enhanced reimbursement and are independent of specific health plan medical policy coverage criteria. Health plan medical policy/clinical guidelines should be consulted to determine whether proposed services will be covered.


Park SH, Sohn TS, Lee J, et al. Phase III trial to compare adjuvant chemotherapy with capecitabine and cisplatin versus concurrent chemoradiotherapy in gastric cancer: final report of the adjuvant chemoradiotherapy in stomach tumors trial, including survival and subset analyses. J Clin Oncol. 2015; Jan 5. PMID: 25559811


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# Head and Neck Cancer Pathways

<table>
<thead>
<tr>
<th>Hypopharynx and larynx: candidate for local therapy (M0)</th>
<th>Primary systemic therapy &amp; concurrent radiation therapy (RT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High dose cisplatin* with concurrent RT</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hypopharynx and larynx: candidate for local therapy (M0)</th>
<th>Post-operative systemic therapy &amp; concurrent radiation therapy (RT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High dose cisplatin* with concurrent RT</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lip, oral cavity, oropharynx, ethmoid sinus, maxillary sinus, occult primary: candidate for local therapy (M0)</th>
<th>Primary systemic therapy &amp; concurrent radiation therapy (RT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High dose cisplatin* with concurrent RT</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lip, oral cavity, oropharynx, ethmoid sinus, maxillary sinus, occult primary: candidate for local therapy (M0)</th>
<th>Post-operative systemic therapy &amp; concurrent radiation therapy (RT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High dose cisplatin* with concurrent RT</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nasopharynx: candidate for local therapy (M0)</th>
<th>Primary systemic therapy &amp; concurrent radiation therapy (RT) followed by adjuvant therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>High dose cisplatin* with concurrent RT, followed by adjuvant cisplatin and fluorouracil (5FU)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nasopharynx</th>
<th>Metastatic and recurrent disease</th>
<th>First and subsequent lines of therapy (1st line +)</th>
<th>Performance Status 0, 1, 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carboplatin</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cisplatin</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cisplatin† and gemcitabine (Gemzar)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cisplatin† and paclitaxel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluorouracil (5FU)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gemcitabine (Gemzar)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gemcitabine (Gemzar) and vinorelbine (Navelbine)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methotrexate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paclitaxel</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Nasopharyngeal (Squamous cell)</th>
<th>Metastatic and recurrent disease</th>
<th>First line of therapy (1st line)</th>
<th>Performance Status 0, 1, 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carboplatin, fluorouracil (5FU), and cetuximab (Erbitux)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cisplatin fluorouracil (5FU), and cetuximab (Erbitux)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-nasopharyngeal (Squamous cell)</th>
<th>Metastatic and recurrent disease</th>
<th>Second and subsequent lines of therapy (2nd line +)</th>
<th>Performance Status 0, 1, 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nivolumab (Opdivo)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paclitaxel</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* High dose cisplatin is defined as dosing to achieve 200-300 mg/m² total cisplatin dose during the course of radiotherapy

† Substitution of carboplatin for cisplatin, and vice-versa, is acceptable for metastatic disease

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Hodgkin Lymphoma Pathways

Classical Hodgkin Lymphoma | Early Stage (Stage I-IIA, favorable and unfavorable risk)

**ABVD**: doxorubicin (Adriamycin), bleomycin, vinblastine, and dacarbazine (DTIC) ± ISRT*1,3,4,5,30

Classical Hodgkin Lymphoma | Advanced Stage (Stage IIB, III, and IV)

**ABVD**: doxorubicin (Adriamycin), bleomycin, vinblastine, and dacarbazine (DTIC) ± ISRT*7,8,9,10,32

* ISRT – Involved Site Radiation Therapy

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Effective August 1, 2017
HODGKIN LYMPHOMA REFERENCES


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# Kidney Cancer (Renal Cell Carcinoma) Pathways

## Metastatic disease | First line of therapy (1st line)

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>High dose intravenous (IV) interleukin-2 (IL2, Proleukin)(^{17,18}) (clear cell only)</td>
<td></td>
</tr>
<tr>
<td>Pazopanib (Votrient)(^{4,5,7})</td>
<td></td>
</tr>
</tbody>
</table>

## Metastatic disease | First line of therapy (1st line) | Poor prognosis* or Non-clear cell histology

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temsirolimus (Torisel)(^{23})</td>
<td></td>
</tr>
</tbody>
</table>

## Metastatic disease | Second or subsequent lines of therapy (2nd line+) | Clear cell carcinoma

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nivolumab (Opdivo)(^{29})</td>
<td></td>
</tr>
</tbody>
</table>

---

* Poor prognosis patients have 3 or more of the following predictors of short survival:
  
  - LDH greater than 1.5 x normal
  - Hemoglobin less than normal (anemia)
  - Corrected serum calcium (Ca) greater than 10 ng/dL
  - Less than 1 year from diagnosis to the start of systemic therapy
  - Karnofsky performance status ≤ 70 (Unable to carry on normal activity or do active work, but able to perform self-care)
  - 2 or more sites of organ metastases

---

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KIDNEY CANCER (RENAL CELL CARCINOMA) REFERENCES


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Effective August 1, 2017
# Lung Cancer: Non-Small Cell Lung Cancer (NSCLC) Pathways

## Adjuvant
- Carboplatin and paclitaxel
- Cisplatin and gemcitabine (Gemzar)
- Cisplatin and vinorelbine (Navelbine)

## Primary therapy | Locally advanced / Unresectable disease | Stage III
- Cisplatin and etoposide (Toposar) with concurrent XRT
- Paclitaxel and carboplatin with concurrent XRT

## Metastatic disease | ALK positive or ROS1 positive | First line of therapy (1st line)
- Crizotinib (Xalkori)

## Metastatic disease | EGFR positive | First line of therapy (1st line)
- Erlotinib (Tarceva)

## Metastatic disease | PD-L1 Expression High (≥50%) | EGFR and ALK negative | First line of therapy (1st line) | ECOG Performance Status = 0, 1, 2
- Pembrolizumab (Keytruda)\(^{105, 106}\)

## Metastatic disease | Non-squamous | First line of therapy (1st line) | ECOG Performance Status = 0, 1, 2
- Carboplatin\(^*\) and paclitaxel
- Carboplatin, paclitaxel, and bevacizumab (Avastin)
- Cisplatin\(^*\) and gemcitabine (Gemzar)
- Cisplatin\(^*\) and pemetrexed (Alimta)

## Metastatic disease | Squamous | First line of therapy (1st line) | ECOG Performance Status = 0, 1, 2
- Carboplatin\(^*\) and paclitaxel
- Cisplatin\(^*\) and gemcitabine (Gemzar)

\(^*\) Administered at a dose of 2 mg/kg (up to a maximum of 200 mg).

\(^\d\) In the setting of recurrent/metastatic NSCLC, a substitution of carboplatin for cisplatin (or vice-versa) will be considered a Pathway option.

---

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Lung Cancer: Non-Small Cell Lung Cancer (NSCLC) Pathways (continued)

<table>
<thead>
<tr>
<th>Metastatic disease</th>
<th>Non-squamous</th>
<th>Maintenance</th>
<th>ECOG Performance Status = 0, 1, 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Continuation bevacizumab (Avastin)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Continuation pemetrexed (Alimta)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Switch pemetrexed (Alimta)</td>
</tr>
<tr>
<td>Metastatic disease</td>
<td>EGFR T790M mutation</td>
<td>Second line (2nd line) after targeted 1st line therapy</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Osimertinib (Tagrisso)†</td>
</tr>
<tr>
<td>Metastatic disease</td>
<td>ALK positive or EGFR positive</td>
<td>Second or subsequent lines of therapy (2nd line +)</td>
<td>ECOG Performance Status = 0, 1, 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Carboplatin* and paclitaxel</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cisplatin* and gemcitabine (Gemzar)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cisplatin* and pemetrexed (Alimta)</td>
</tr>
<tr>
<td>Metastatic disease</td>
<td>Second or subsequent lines of therapy (2nd line+)</td>
<td>ECOG Performance Status = 0, 1, 2</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Atezolizumab (Tecentriq)</td>
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<td></td>
<td></td>
<td></td>
<td>Nivolumab (Opdivo) (any histology/pathology)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Pemetrexed (Alimta) (Non-Squamous histology/pathology)</td>
</tr>
<tr>
<td>Metastatic disease</td>
<td>EGFR positive</td>
<td>ECOG Performance Status = 3, 4</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Erlotinib (Tarceva)</td>
</tr>
</tbody>
</table>

* In the setting of recurrent/metastatic NSCLC, a substitution of carboplatin for cisplatin (or vice-versa) will be considered a Pathway option

† For patients with EGFR T790M mutation

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LUNG CANCER: NON-SMALL CELL LUNG CANCER (NSCLC)

REFERENCES


14. FDA review documents


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# Lung Cancer: Small Cell Lung Cancer Pathways

## Limited Stage | Primary, Adjuvant, or First Line Therapy (1st line)
- Carboplatin and etoposide (Toposar) ± XRT
- Cisplatin and etoposide (Toposar) ± XRT

## Extensive Stage | First line of therapy (1st line)
- Carboplatin and etoposide (Toposar)

## Second and subsequent lines of therapy (2nd line +) | Relapse greater than 6 months
- Carboplatin and etoposide (Toposar)

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Lung Cancer: Small Cell Lung Cancer References


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Effective August 1, 2017
Melanoma Pathways: Metastatic Melanoma

<table>
<thead>
<tr>
<th>Metastatic disease</th>
<th>First and subsequent lines of therapy (1st line +)</th>
<th>Any BRAF status</th>
<th>ECOG PS: 0, 1, 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nivolumab (Opdivo)(^{20,31,32}) <strong>No Longer Pathway Effective 8/1/2017</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pembrolizumab (Keytruda)(^{+35,45,55,56}) <strong>(Added Effective 8/1/2017)</strong></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Metastatic disease</th>
<th>First line of therapy (1st line)</th>
<th>BRAF mutated (^{†})</th>
<th>Symptomatic disease</th>
<th>ECOG PS: 0, 1, 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vemurafenib (Zelboraf) and cobimetinib (Cotellic)(^{26,40-42})</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Metastatic disease</th>
<th>Second and subsequent lines of therapy (2nd line +)</th>
<th>BRAF mutated (^{†})</th>
<th>ECOG PS: 0, 1, 2</th>
</tr>
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<tbody>
<tr>
<td>Vemurafenib (Zelboraf) and cobimetinib (Cotellic)(^{26,40-42})</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Metastatic disease</th>
<th>Second and subsequent lines of therapy (2nd line +)</th>
<th>Any BRAF status</th>
<th>ECOG PS: 0, 1, 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ipilimumab (Yervoy)(^{1,14,15,35,36})</td>
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</tbody>
</table>

* Administered at a dose of 2 mg/kg (up to a maximum of 200 mg).

† BRAF mutations include V600E and V600K mutations.

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MELANOMA: METASTATIC MELANOMA REFERENCES


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47 Asciento PA, McArthur GA, Dréno B, et. al. Cobimetinib combined with vemurafenib in advanced BRAF(V600)-mutant melanoma (coBRIM): updated efficacy results from a randomised, double-blind, phase 3 trial. Lancet Oncol. 2016 Sep;17(9):1248-60. PMID: 27480103


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# Myeloma Pathways: Multiple Myeloma

## Primary/ First line of therapy (1st line) | Transplant candidates

**VRD/VDR**: bortezomib (Velcade), lenalidomide (Revlimid), and dexamethasone\(^{10,12,79}\)

## Primary/ First line of therapy (1st line) | Ineligible for transplant

**CyBorD or VDC**: bortezomib (Velcade), cyclophosphamide, and dexamethasone\(^{9,10,84}\)

**R-dex**: lenalidomide (Revlimid) and low-dose dexamethasone\(^{10,11,13,73}\)

**VRD/VDR**: bortezomib (Velcade), lenalidomide (Revlimid), and dexamethasone \(^{10,12,79}\)

**VD**: bortezomib (Velcade) and dexamethasone \(^{1,3,12,24,89}\)

## Maintenance therapy | Post-transplant

Lenalidomide (Revlimid)\(^{26,27,83,92}\)

## Relapsed disease | Second and subsequent lines of therapy (2nd line +)

**CRd or KRd**: carfilzomib (Kyprolis), lenalidomide (Revlimid), and dexamethasone\(^{82}\)

**DRD**: daratumumab (Darzalex), lenalidomide (Revlimid), and dexamethasone\(^{100}\)

**DVD**: daratumumab (Darzalex), bortezomib (Velcade), and dexamethasone\(^{103}\)

## Relapsed disease | Third and subsequent lines of therapy (3rd line +)

Daratumumab (Darzalex)\(^{95}\)

Elotuzumab (Empliciti), lenalidomide (Revlimid), and dexamethasone\(^{97}\)

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Effective August 1, 2017
Effective August 1, 2017

MYELOMA: MULTIPLE MYELOMA REFERENCES


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104 Pawlyn CD, FE; Kaiser, MF; et al. Primary IMiD Refractory Myeloma; Results from 3894 Patients Treated in the Phase III Myeloma XI Study. American Society of Hematology; San Diego CA2016. ASH Abstract 1144


NCCN Clinical Practice Guidelines


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Effective August 1, 2017
NHL: Chronic Lymphocytic Leukemia (CLL)/ Small Lymphocytic Lymphoma (SLL) Pathways

First line of therapy (1st line) | With 17p Deletion

Ibrutinib (Imbruvica)28,37,41,46,47

First line of therapy (1st line) | Without 17p Deletion

BR: bendamustine (Bendeka, Treanda) and rituximab (Rituxan)13,14,15,39,51
FCR: fludarabine (Fludara), cyclophosphamide, and rituximab (Rituxan)1,2,39,51
Ibrutinib (Imbruvica)29,37,46,47

Second and subsequent lines of therapy (2nd line +) | With 17p Deletion

Ibrutinib (Imbruvica)28,37,41,46,47

Second and subsequent lines of therapy (2nd line +) | Without 17p Deletion

BR: bendamustine (Bendeka, Treanda) and rituximab (Rituxan)13,14,15,42
Ibrutinib (Imbruvica)28,37,41,46,47

Indications to initiate treatment may include (not limited to):

1. WBC elevation above 200-300 x 10⁹
2. Signs of leukostasis
3. Lymphocyte doubling time of less than 6 months
4. In low or intermediate risk disease:
   a. Significant disease-related symptoms such as severe fatigue, weight loss, night sweats, otherwise unexplained fever
   b. Signs of end-organ damage
   c. Significant or progressive bulky disease, such as massive splenomegaly (≥6 cm below the costal margin) or massive lymphadenopathy (> 10 cm in longest diameter)
   d. Clinically significant progressive or symptomatic anemia or thrombocytopenia
      i. Not caused by autoimmune etiology, unless poor response to conventional immunosuppressive therapy
5. High risk disease, particularly with progressive cytopenias

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Effective August 1, 2017
NHL: CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) / SMALL LYMPHOCYTIC LYMPHOMA (SLL) REFERENCES


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Effective August 1, 2017
NHL: Diffuse Large B-Cell Lymphoma Pathways

First line of therapy (1st line)

R-CHOP (21): cyclophosphamide, doxorubicin (Adriamycin), vincristine (Vincasar), prednisone, and rituximab (Rituxan)1-4

First line of therapy (1st line) | Contraindication to anthracycline

R-CEOP: cyclophosphamide, etoposide (Toposar), vincristine (Vincasar), prednisone, and rituximab (Rituxan)13,14,40,41

Second and subsequent lines of therapy (2nd line +) | Transplant candidates

R-GDP: gemcitabine (Gemzar), dexamethasone, cisplatin, and rituximab (Rituxan) OR gemcitabine (Gemzar), dexamethasone, carboplatin, and rituximab (Rituxan)23,24,43

R-ICE: ifosfamide (Ifex), carboplatin, etoposide (Toposar), and rituximab (Rituxan)18,19,29

Second and subsequent lines of therapy (2nd line +) | Non-Transplant candidates

BR: bendamustine (Bendeka, Treanda) and Rituximab (Rituxan)32,33

R-GDP: gemcitabine (Gemzar), dexamethasone, cisplatin, and rituximab (Rituxan) OR gemcitabine (Gemzar), dexamethasone, carboplatin, and rituximab (Rituxan)23,24

R-GemOx: gemcitabine (Gemzar), oxaliplatin, and rituximab (Rituxan)25-27

R-ICE: ifosfamide (Ifex), carboplatin (Paraplatin), etoposide (Toposar), and rituximab (Rituxan)18,19,29 No Longer Pathway Effective 8/1/2017

Rituximab (Rituxan) monotherapy reserved for frail patients or elderly patients

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Effective August 1, 2017

NHL: DIFFUSE LARGE B CELL LYMPHOMA REFERENCES


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# NHL: Follicular and Marginal Zone Lymphoma Pathways

<table>
<thead>
<tr>
<th><strong>Gastric MALT (Mucosa-associated Lymphoid Tissue) Lymphoma: Stage IE or IIE, \textit{H. pylori} positive</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibiotic therapy for \textit{H. pylori} eradication\textsuperscript{33,34}</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Splenic Marginal Zone Lymphoma \textsuperscript{†} OR Gastric MALT Lymphoma: First line of therapy (1st line)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rituximab (Rituxan) monotherapy\textsuperscript{27-29}</td>
</tr>
</tbody>
</table>

| **Follicular (Grade I-IIIA) Lymphoma and other Marginal Zone Lymphomas | First line of therapy (1st line)** |
|------------------------------------------------------------------------------------------------------------------|
| **BR:** Bendamustine (Bendeka, Treanda) and rituximab (Rituxan)\textsuperscript{5,6} |
| **R-CHOP(21):** Cyclophosphamide, doxorubicin (Adriamycin), vincristine (Vincasar), prednisone, and rituximab (Rituxan)\textsuperscript{1-3,5} |
| **R-CVP:** Cyclophosphamide, vincristine (Vincasar), prednisone, and rituximab (Rituxan)\textsuperscript{1,4} |
| Rituximab (Rituxan) monotherapy\textsuperscript{7,17} |

| **Follicular Lymphoma and other Marginal Zone Lymphomas | First line of therapy (1st line) | Additional options for the elderly or infirm** |
|------------------------------------------------------------------------------------------------------------------|
| Chlorambucil (Leukeran)\textsuperscript{10} |
| Chlorambucil (Leukeran) and rituximab (Rituxan)\textsuperscript{10,11} |
| Cyclophosphamide\textsuperscript{11-13} |
| Cyclophosphamide and rituximab (Rituxan) |

| **Follicular Lymphoma (Grade III) | First line of therapy (1st line)** |
|------------------------------------------------------------------------------------------------------------------|
| **R-CHOP(21):** Cyclophosphamide, doxorubicin (Adriamycin), vincristine (Vincasar), prednisone, and rituximab (Rituxan)\textsuperscript{1-5} |
| **R-CEOP:** Cyclophosphamide, etoposide (Toposar), vincristine (Vincasar), prednisone, and rituximab (Rituxan)\textsuperscript{13,35-37} |

\*Gastric MALT with translocation 11:18 (t11;18) (q21;q21) predicts a lower response rate to anti-\textit{H. pylori} treatment. Radiation therapy or other local intervention may be indicated.

\†Splenectomy is also a recommended option for Splenic Marginal Zone Lymphoma (NCCN 2A).

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**NHL: FOLLICULAR AND MARGINAL ZONE LYMPHOMA REFERENCES**


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NHL: Mantle Cell Lymphoma Pathways

<table>
<thead>
<tr>
<th>First line of therapy (1st line)</th>
<th>ASCT Candidates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nordic Regimen</strong>: dose intensified rituximab (Rituxan), cyclophosphamide, vincristine (Vincasar), doxorubicin (Adriamycin), prednisone alternating with rituximab (Rituxan) and high dose cytarabine (Depocyt)³</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First line of therapy (1st line)</th>
<th>Not ASCT Candidates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BR</strong>: bendamustine (Bendeka, Treanda) and rituximab (Rituxan)⁹,¹⁰</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Second and subsequent lines of therapy (2nd line +)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BR</strong>: bendamustine (Bendeka, Treanda) and rituximab (Rituxan)</td>
</tr>
<tr>
<td>Bortezomib (Velcade)¹⁷</td>
</tr>
<tr>
<td>Ibrutinib (Imbruvica)¹⁹,²⁰</td>
</tr>
</tbody>
</table>

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NHL: MANTLE CELL LYMPHOMA REFERENCES


13. Forstpointner R, Dreyling M, German Low-Grade Lymphoma Study Group, et al. The addition of rituximab to a combination of fludarabine, cyclophosphamide, mitoxantrone (FCM) significantly increases the response rate and prolongs survival as compared with FCM alone in patients with relapsed and refractory follicular and mantle cell lymphomas: results of a prospective randomized study of the German Low-Grade Lymphoma Study Group. Blood. 2004 Nov 15;104(10):3064-3071. PMID: 15284112


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Ovarian Cancer (Epithelial) Pathways

**Adjuvant Therapy | Stage IA/B (Grade 2 or 3) or IC (Grade 1-3)**

- Carboplatin and dose dense (weekly) paclitaxel
- Carboplatin and paclitaxel

**Adjuvant or Primary Therapy | Stage II, III, IV**

- Carboplatin and dose dense (weekly) paclitaxel (Taxol)
- Intravenous (IV) paclitaxel and Intraperitoneal (IP) cisplatin and IP paclitaxel (Stage III only)

**Recurrent Disease | First and subsequent lines of therapy (1st line +) | Platinum-sensitive***

- Carboplatin
- Carboplatin and gemcitabine (Gemzar)
- Carboplatin and paclitaxel
- Carboplatin and weekly paclitaxel

**Recurrent Disease | Second and subsequent lines of therapy (2nd line +) | Platinum resistant**

- Bevacizumab (Avastin) monotherapy
- Docetaxel (Taxotere)
- Gemcitabine (Gemzar)
- Liposomal doxorubicin (Doxil or Lipodox)
- Paclitaxel (weekly)
- Paclitaxel and bevacizumab (Avastin)
- Topotecan (Hycamtin)
- Topotecan (Hycamtin) and bevacizumab (Avastin)
- Vinorelbine (Navelbine)

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* Platinum sensitive disease is defined as recurrence of greater than 6 months after prior platinum-based therapy

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Effective August 1, 2017

**OVARIAN CANCER (EPITHELIAL) REFERENCES**


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# Pancreatic Cancer (Adenocarcinoma) Pathways

## Adjuvant Therapy

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capecitabine (Xeloda) and gemcitabine (Gemzar)</td>
<td>Added Effective 8/1/2017</td>
</tr>
<tr>
<td>Fluorouracil (5FU) and leucovorin</td>
<td></td>
</tr>
<tr>
<td>Gemcitabine (Gemzar) monotherapy</td>
<td></td>
</tr>
</tbody>
</table>

## Locally Advanced/Unresectable and Metastatic Disease | First line of therapy (1st line) | ECOG PS: 0, 1, 2

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOLFIRINOX: fluorouracil (5FU), leucovorin, irinotecan (Camptosar), and oxaliplatin</td>
<td></td>
</tr>
<tr>
<td>Gemcitabine (Gemzar)</td>
<td></td>
</tr>
<tr>
<td>Gemcitabine (Gemzar) and nab-paclitaxel (Abraxane)</td>
<td></td>
</tr>
</tbody>
</table>

## Locally Advanced/Unresectable and Metastatic Disease | Second line of therapy (2nd line) | ECOG PS: 0, 1, 2

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>OFF: Fluorouracil (5FU), leucovorin, and oxaliplatin</td>
<td></td>
</tr>
<tr>
<td>Gemcitabine (Gemzar) monotherapy</td>
<td></td>
</tr>
</tbody>
</table>

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Effective August 1, 2017
Pancreatic Cancer (Adenocarcinoma) References


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34 Tempero MA, Cardin DB, Blankin A, et al. nab-paclitaxel (nab-P) plus gemcitabine (Gem) vs Gem alone as adjuvant treatment for resected pancreatic cancer (PC) in a phase III trial (APACT). J Clin Oncol 33, 2015 (suppl; abstr TPS4153). Abstract 4153


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Effective August 1, 2017
Prostate Cancer (Adenocarcinoma) Pathways

**Adjuvant Therapy | Post-prostatectomy | Lymph node positive (LN+)**
- Goserelin (Zoladex)\(^{1,2}\)
- Leuprolide ( Eligard/Lupron)\(^{1,2}\)
- Triptorelin (Trelstar)\(^{1,2}\)

**Intermediate risk | Primary treatment with radiotherapy (RT)**
- Goserelin* (Zoladex)\(^{3,5}\)
- Leuprolide* (Eligard/Lupron)\(^{3,5}\)
- Triptorelin* (Trelstar)\(^{2,5}\)

**High Risk (T3a or Gleason 8-10), Very High Risk (T3b-T4), and Locally Advanced Prostate Cancer (LN+) | Primary treatment with radiotherapy**
- Goserelin* (Zoladex)\(^{4}\)
- Goserelin* (Zoladex) with docetaxel (Taxotere) (every 3 weeks)
- Leuprolide* (Eligard/Lupron)\(^{4}\)
- Leuprolide* (Eligard/Lupron) with docetaxel (Taxotere) (every 3 weeks)
- Triptorelin* (Trelstar)\(^{4}\)
- Triptorelin* (Trelstar) with docetaxel (Taxotere) (every 3 weeks)

**Recurrent and Metastatic disease | Hormone Sensitive**
- Docetaxel (Taxotere) (every 3 weeks) with Androgen Deprivation Therapy (ADT)\(^†\)\(^{19}\)
- Goserelin (Zoladex)\(^{6}\)
- Leuprolide (Eligard/Lupron)\(^{6}\)
- Triptorelin (Trelstar)\(^{6}\)

Bilateral orchiectomy (surgical castration) is an equally effective alternative to medical castration

* May be coadministered with bicalutamide (Casodex) or flutamide (Eulexin) for up to 30-60 days in patients who are at risk of developing symptoms associated with testosterone flare

† ADT Pathway options, when given as listed above: goserelin (Zoladex), leuprolide (Eligard/Lupron), triptorelin (Trelstar) or history of orchiectomy

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Prostate Cancer (Adenocarcinoma) Pathways (continued)

Recurrent and Metastatic Disease | Hormone Resistant | First line of therapy (1st line)

- Abiraterone** (Zytiga) and prednisone with continue ADT**8,12,25,26,27
- Docetaxel** (Taxotere) (every 3 weeks) with continue ADT**9,10,19
- Enzalutamide (Xtandi)
- Enzalutamide (Xtandi) with goserelin (Zoladex)
- Enzalutamide (Xtandi) with leuprolide ( Eligard/Lupron)
- Enzalutamide (Xtandi) with triptorelin (Trelstar)
- Goserelin (Zoladex) with bicalutamide (Casodex)6,7
- Leuprolide (Eligard/Lupron) with bicalutamide (Casodex)6,7
- Triptorelin (Trelstar) with bicalutamide (Casodex)6,7

Recurrent and Metastatic Disease | Hormone Resistant | Second and subsequent lines of therapy (2nd line+)

- Abiraterone (Zytiga)** and prednisone with continue ADT**†8,12,25,26,27
- Cabazitaxel (Jevtana) with ADT **11
- Docetaxel** (Taxotere) (every 3 weeks) with continue ADT**‡9,10,19
- Docetaxel (Taxotere) rechallenge with ADT**21,22
- Goserelin (Zoladex) with bicalutamide (Casodex) ‡6,7
- Leuprolide (Eligard/Lupron) with bicalutamide (Casodex)‡6,7
- Triptorelin (Trelstar) with bicalutamide (Casodex)‡6,7
- Continued ADT** with supportive care ± dexamethasone13,14,15,16,24

Bilateral orchiectomy (surgical castration) is an equally effective alternative to medical castration

*May be coadministered with bicalutamide (Casodex) or flutamide (Eulexin) for up to 30-60 days in patients who are at risk of developing symptoms associated with testosterone flare.

**ADT Pathway options, when given as listed above: goserelin (Zoladex), leuprolide ( Eligard/Lupron), triptorelin (Trelstar), or history of orchiectomy

† If neither abiraterone nor enzalutamide have been previously used

‡ If not previously used in the first line (1st Line) setting

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PROSTATE CANCER (ADENOCARCINOMA) REFERENCES


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Effective August 1, 2017
## Testicular (Germ Cell Tumors) Cancer Pathways

### Seminoma | Stage II-IIIA | Primary Therapy

**BEP:** bleomycin, etoposide (Toposar), and cisplatin

**EP:** etoposide (Toposar) and cisplatin

### Seminoma | Stage IIIB-C | Good Risk | and Metastatic Disease

**BEP:** bleomycin, etoposide (Toposar), and cisplatin

### Nonseminoma | Stage II-IIIA | Primary Therapy

**BEP:** bleomycin, etoposide (Toposar), and cisplatin

**EP:** etoposide (Toposar) and cisplatin

### Nonseminoma | Stage IIIB-C | Primary Therapy

**BEP:** bleomycin, etoposide (Toposar), and cisplatin

### Nonseminoma | Adjuvant Therapy after RPLND*

**EP:** etoposide (Toposar) and cisplatin

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*RPLND: Retroperitoneal Lymph Node Dissection

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Effective August 1, 2017
TESTICULAR (GERM CELL TUMORS) CANCER REFERENCES


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24 Miller JC, Einhorn LH. Phase II study of daily oral etoposide in refractory germ cell tumors. Semin Oncol. 1990 Feb;17(1 Suppl 2):36-9. PMID: 2154858


**NCCN Practice Guidelines: Testicular Cancer V2.2017.**


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Effective August 1, 2017
Uterine (Endometrial) Cancer Pathways

<table>
<thead>
<tr>
<th>Adjuvant Therapy</th>
<th>Stage III-IV or High Risk Histologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carboplatin and paclitaxel&lt;sup&gt;6,6&lt;/sup&gt;</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recurrent / Metastatic</th>
<th>First and Subsequent Lines of Therapy (1&lt;sup&gt;st&lt;/sup&gt; line +)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carboplatin and paclitaxel&lt;sup&gt;5,27-29&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Cisplatin and doxorubicin (Adriamycin)&lt;sup&gt;24,25&lt;/sup&gt;</td>
<td></td>
</tr>
</tbody>
</table>

Note: Pathway lists are solely for the purpose of eligibility for enhanced reimbursement and are independent of specific health plan medical policy coverage criteria. Health plan medical policy/clinical guidelines should be consulted to determine whether proposed services will be covered.

Effective August 1, 2017
UTERINE (ENDOMETRIAL) CANCER REFERENCES


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