Abraxane (paclitaxel, protein-bound)
CG-DRUG-50

Override | Approval Duration
---|---
Prior Authorization | 1 year

Medication
Abraxane (paclitaxel, protein-bound)

**APPROVAL CRITERIA**

Requests for Abraxane (paclitaxel, protein-bound) may be approved when the following criteria are met:

I. Breast Cancer
   A. Individual has relapsed or has metastatic breast cancer and meets the following criteria:
      1. Abraxane is being used as a single agent; **AND**
      2. Abraxane is being used in a single line of therapy.

   **OR**
   B. Individual has any breast cancer and Abraxane is being used as a substitute for solvent-based paclitaxel or docetaxel secondary to documented allergic reaction.

II. Malignant Melanoma
   A. Individual has relapsed or has refractory melanoma and meets the following criteria:
      1. Abraxane is being used as a single agent; **AND**
      2. Individual has an Eastern Cooperative Oncology Group (ECOG) performance status of 0-2 following at least one prior therapy.

III. Non-Small Cell Lung Cancer (NSCLC)
   A. Individual has locally advanced or metastatic NSCLC and meets the following criteria:
      1. Abraxane is being used as first-line therapy; **AND**
      2. Abraxane is being given in combination with carboplatin or cisplatin.

This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.

WEB-PEC-0613-17
OR

B. Abraxane is being used as a substitute for either solvent-based paclitaxel or docetaxel secondary to documented allergic reaction or when conventional premedications (that is, corticosteroids [such as dexamethasone], histamine H1 antagonists, or histamine H2 antagonists) are contraindicated.

IV. Ovarian Cancer (Epithelial Ovarian Cancer, Fallopian Tube Cancer, or Primary Peritoneal Cancer)

A. Individual has ovarian cancer (epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer) and meets the following criteria:
   1. Abraxane is being used as a single agent; **AND**
   2. Disease is persistent or recurrent.

V. Pancreatic Cancer

A. Individual has locally advanced or metastatic adenocarcinoma of the pancreas and meets the following criteria:
   1. Abraxane is being used as first-line therapy or later; **AND**
   2. Abraxane is being given in combination with gemcitabine as a single-line of therapy.

Abraxane (paclitaxel, protein-bound) **may not be approved** when the above criteria are not met and for all other indications.

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**State Specific Mandates**

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<th>State name</th>
<th>Date effective</th>
<th>Mandate details (including specific bill if applicable)</th>
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**Key References:**


This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.
### Market Applicability/Effective Date

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*FHK- Florida Healthy Kids


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