Clinical Policy: Tepotinib (Tepmetko)

Reference Number: CP.PHAR.530
Effective Date: 06.01.21
Last Review Date: 05.25
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Tepotinib (Tepmetko®) is a kinase inhibitor that targets mesenchymal-epithelial transition (*MET*).

FDA Approved Indication(s)

Tepmetko is indicated for the treatment of adult patients with metastatic non-small cell lung cancer (NSCLC) harboring *MET* exon 14 skipping alterations.

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® that Tepmetko is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Non-Small Cell Lung Cancer (must meet all)**:**

1. Diagnosis of recurrent, advanced, or metastatic NSCLC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is positive for a mutation causing *MET* exon 14 skipping or high-level *MET* amplification;
5. For NSCLC that is *MET* exon 14 skipping-positive: Member has not had progression with a MET exon 14 skipping mutation-targeting regimen (e.g., Tepmetko, Tabrecta®, Xalkori®);
6. Prescribed in one of the following ways (a or b):
   a. As a single agent;
   b. For high-level *MET* amplification positive NSCLC with an existing EGFR mutation: Tepmetko can be administered with continuation of Tagrisso®;
7. For Tepmetko requests, member must use generic tepotinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
8. Request meets one of the following (a or b):*
   a. Dose does not exceed 450 mg (2 tablets) per day;
   b. 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. 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. Non-Small Cell Lung Cancer (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Tepmetko for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Tepmetko requests, member must use generic tepotinib, 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 450 mg (2 tablets) per day;
   b. 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

ALK: anaplastic lymphoma kinase
EGFR: epidermal growth factor receptor
FDA: Food and Drug Administration
MET: mesenchymal-epithelial transition
NCCN: National Comprehensive Cancer Network
NSCLC: non-small cell lung cancer

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information

- *MET* amplification is an oncogenic driver occurring in 1% to 5% of NSCLCs that confers a poor prognosis. High-level *MET* amplification is an emerging biomarker to identify novel therapies for patients with metastatic NSCLC per NCCN. The definition of high-level *MET* amplification is evolving and may differ according to the assay used for testing. For results based on next-generation sequencing, a gene copy number greater than 10 is consistent with high-level *MET* amplification.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
NSCLC	450 mg PO QD	450 mg/day

VI. Product Availability

Tablet: 225 mg

VII. References

1. Tepmetko Prescribing Information. Rockland, MA: EMD Serono, Inc.; February 2024. Available at: www.tepmetko.com. Accessed January 29, 2025.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed February 19, 2025.
3. NCCN Clinical Practice Guidelines in Oncology: Non-Small Cell Lung Cancer Version 3.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed February 19, 2025.
4. Paik PK, Felip E, Veillon R, et al. Tepotinib in Non–Small-Cell Lung Cancer with MET Exon 14 Skipping Mutations. N Engl J Med 2020;383:931-43.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	02.11.21	05.21
2Q 2022 annual review: added indication of high-level *MET* amplification in NSCLC per NCCN category 2A; added qualifier for recurrent NSCLC; removed criteria for EGFR wild-type and ALK negative statuses and exclusion for CNS metastases neither NCCN nor the FDA labeling support this restriction; added generic redirection criterion; Commercial approval durations revised from "Length of Benefit" to "12 months or duration of request, whichever is less"; references reviewed and updated.	02.13.22	05.22
Template changes applied to other diagnoses/indications.	10.05.22	
2Q 2023 annual review: For NSCLC that is *MET* exon 14 skipping-positive, added exclusion for previous progression with a MET exon 14 skipping mutation-targeted regimen per NCCN Compendium and New Century Health criteria; added monotherapy criterion per NCCN and New Century Health criteria; references reviewed and updated.	02.04.23	05.23
2Q 2024 annual review: no significant changes; RT4: updated the FDA-approved indication with conversion from accelerated approval to full approval; references reviewed and updated.	02.26.24	05.24
2Q 2025 annual review: added option for combination with continued Tagrisso if member has high-level *MET* amplification and an *EGFR* mutation per NCCN Compendium; references reviewed and updated.	02.19.25	05.25

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.