MEDICAL MUTUAL®

# Drug Policy

| Policy: | Xermelo (telotristat ethyl) | Annual Review Date:<br>12/21/2023<br>Last Revised Date:<br>12/21/2023 |
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## OVERVIEW

Xermelo is indicated for the treatment of carcinoid syndrome diarrhea in combination with somatostatin analog (SSA) therapy in adults inadequately controlled by SSA therapy. Telotristat, the active metabolite, inhibits tryptophan hydroxylase, which mediates the rate limiting step in serotonin biosynthesis. Serotonin plays a role in mediating secretion, motility, inflammation, and sensation of the gastrointestinal tract and is overproduced in patients with carcinoid syndrome. Xermelo specifically reduces the production of peripheral serotonin and decreases the frequency of carcinoid syndrome diarrhea. The inclusion criteria for the TELESTAR pivotal study required all patients randomized to Xermelo or placebo groups to have at least four bowel movements per day while on SSA therapy. The study also required patients to be receiving a stable dose of SSA therapy for at least 3 months prior to trial enrollment.

## POLICY STATEMENT

This policy involves the use of Xermelo. Prior authorization is recommended for pharmacy benefit coverage of Xermelo. Approval is recommended for those who meet the conditions of coverage in the **Criteria and Initial/Extended Approval** for the diagnosis provided. **Conditions Not Recommended for Approval** are listed following the recommended authorization criteria. Requests for uses not listed in this policy will be reviewed for evidence of efficacy and for medical necessity on a case-by-case basis.

Because of the specialized skills required for evaluation and diagnosis of patients treated with Xermelo as well as the monitoring required for adverse events and long-term efficacy, initial approval requires Xermelo be prescribed by or in consultation with a physician who specializes in the condition being treated. All approvals for initial therapy are provided for the initial approval duration noted below; if reauthorization is allowed, a response to therapy is required for continuation of therapy unless otherwise noted below.

## RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Xermelo is recommended in those who meet the following criteria:

1. **Carcinoid Syndrome Diarrhea, initial therapy**
   **Criteria.** *Patient must meet the following criteria*
   - **A.** The patient is 18 years of age or older; AND
   - **B.** Xermelo will be used in combination with a long-acting somatostatin analog (SSA) therapy (e.g. Somatuline Depot, Sandostatin LAR); AND
   - **C.** The patient has been using a stable dose of a long-acting SSA (e.g. Somatuline Depot, Sandostatin LAR) for at least 3 consecutive months [documentation required]; AND

**D.** Prior to starting Xermelo, the patient continues to have at least 4 bowel movements per day while on long-acting SSA therapy; AND
**E.** The medication is prescribed by or in consultation with an endocrinologist, oncologist, or gastroenterologist.

**2.** **Carcinoid Syndrome Diarrhea, continuation of therapy**
**Criteria.** *Patient must meet the following criteria*

**A.** The patient is 18 years of age or older; AND
**B.** Xermelo will continue to be used in combination with a long-acting somatostatin analog (SSA) therapy (e.g. Somatuline Depot, Sandostatin LAR); AND
**C.** The patient has had a beneficial response to therapy with Xermelo per the prescribing physician; AND
**D.** The patient has not developed severe constipation; AND
**E.** The medication is prescribed by or in consultation with an endocrinologist, oncologist, or gastroenterologist.

**Initial Approval/ Extended Approval.**
**A)** *Initial Approval:* 1 year
**B)** *Extended Approval:* 1 year

## CONDITIONS NOT RECOMMENDED FOR APPROVAL

Xermelo has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions. (Note: This is not an exhaustive list of Conditions Not Recommended for Approval).

**1.** Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

**Documentation Requirements:**
The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

## REFERENCES

1. Xermelo™ tablets [prescribing information]. The Woodlands, TX: Merck; September 2022.
2. Kulke MH, Horsch D, Caplin ME, et al. Telotristat ethyl, a tryptophan hydroxylase inhibitor for the treatment of carcinoid syndrome. *J Clin Oncol.* 2017;35:14-23.

3. Telotristat ethyl. In: DRUGDEX [online database]. Greenwood Village, CO; Truven Health Analytics. Last updated 24 November 2020. Accessed on 18 November 2021.
4. Telotristat ethyl. In: Lexi-Drugs. Lexicomp. Wolters Kluwer Clinical Drug Information, Inc.; Riverwoods, IL. Available at: http://www.online.lexi.com. Last updated 7 November 2022. Accessed on 7 December 2022.