PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Oral – Anaplastic Lymphoma Kinase [ALK]-Positive Agent) – Xalkori Prior Authorization Policy
- Xalkori® (crizotinib capsules and oral pellets – Pfizer)

REVIEW DATE: 02/04/2026

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Xalkori, an oral kinase inhibitor, is indicated for the following uses:[1]
- **Anaplastic large cell lymphoma (ALCL)**, treatment of relapsed or refractory, systemic ALCL that is anaplastic lymphoma kinase (*ALK)*-positive in pediatric patients ≥ 1 year of age and young adults.
- **Inflammatory Myofibroblastic tumor (IMT),** treatment of unresectable, recurrent, or refractory IMT that is *ALK*-positive in patients ≥ 1 year of age.
- **Non-Small Cell Lung Cancer (NSCLC)**, metastatic, whose tumors are ***ALK*-positive** or c-*rOS* proto-oncogene 1 **(*ROS1)*-positive** as detected by an FDA-approved test in adults.

Guidelines

Xalkori has been addressed in National Comprehensive Cancer Network (NCCN) guidelines:[5-8]

- **Histiocytic Neoplasms:** Guidelines (version 2.2025 – November 21, 2025) recommend Xalkori as a "useful in certain circumstances" treatment option for the following types of histiocytic neoplasm with *ALK* rearrangement/fusion: Langerhans cell histiocytosis, Erdheim-Chester disease, and Rosai-Dorfman disease (category 2A).[3]
- **Inflammatory Myofibroblastic Tumor (IMT):** NCCN Soft Tissue Sarcoma guidelines (version 1.2026 – January 16, 2026) and NCCN Uterine Neoplasms guidelines (version 2.2026 – November 14, 2025) recommend Xalkori as a treatment option for IMT with *ALK* translocation.[4,5]
- **Melanoma, Cutaneous:** Guidelines (version 2.2025 – January 28, 2025) recommend Xalkori as a treatment option for cutaneous melanoma with *ALK* or *ROS1* fusions.[6] Case reports or limited clinical trial data have suggested activity for various gene fusions; Xalkori is noted for *ROS1* and *ALK* fusions.
- **NSCLC:** Guidelines (version 3.2026 – December 24, 2025) recommend Xalkori as a treatment option for *ROS1* rearrangement, *ALK* rearrangement-positive NSCLC, and as a treatment option for NSCLC with mesenchymal-epithelial transition (*MET*) exon 14 skipping mutation or high-level *MET* amplification.[7]
- **T-Cell Lymphoma:** Guidelines (version 1.2026 – December 9, 2025) recommend Xalkori as a treatment option for *ALK*-positive ALCL either as initial palliative-intent therapy or for relapsed or refractory disease.[8] NCCN notes that Xalkori also demonstrated activity in adults with relapsed or refractory *ALK*-positive ALCL, after at least one line of prior cytotoxic therapy.[8]

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Xalkori. All approvals are provided for the duration noted below.

- **Xalkori® (crizotinib capsules and oral pellets - Pfizer)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indications

1. **Anaplastic Large Cell Lymphoma.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   A) Patient is ≥ 1 year of age; AND
   B) Patient has anaplastic lymphoma kinase (*ALK*)-positive disease; AND
   C) Patient meets ONE of the following (i or ii):
      i. The medication is used for palliative-intent therapy; OR
      ii. Patient has relapsed or refractory disease.

2. **Inflammatory Myofibroblastic Tumor.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   A) Patient is ≥ 1 year of age; AND
   B) Patient has anaplastic lymphoma kinase (*ALK*)-positive disease; AND
   C) Patient meets ONE of the following (i or ii):
      i. Patient has advanced, recurrent, or metastatic disease; OR
      ii. The tumor is inoperable.

3. **Non-Small Cell Lung Cancer – Anaplastic Lymphoma Kinase (*ALK*)-Positive.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):

A) Patient is ≥ 18 years of age; AND
B) Patient has advanced or metastatic disease; AND
C) Patient has anaplastic lymphoma kinase (*ALK*)-positive disease.

4. **Non-Small Cell Lung Cancer – *ROS1* Rearrangement-Positive.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has advanced or metastatic disease; AND
   C) Patient has *ROS1* rearrangement-positive disease.

Other Uses with Supportive Evidence

5. **Histiocytic Neoplasm.** Approve for 1 year if patient meets ALL of the following (A, B, and C).
   A) Patient is ≥ 18 years of age; AND
   B) Patient has anaplastic lymphoma kinase (*ALK*) rearrangement/fusion-positive disease; AND
   C) Patient meets ONE of the following (i, ii, or iii):
      i. Patient has Langerhans cell histiocytosis; OR
      ii. Patient had Erdheim-Chester disease; OR
      iii. Patient has Rosai-Dorfman disease.

6. **Melanoma, Cutaneous.** Approve for 1 year if patient meets BOTH of the following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) Patient meets ONE of the following (i or ii):
      i. Patient has anaplastic lymphoma kinase (*ALK*) fusion disease; OR
      ii. Patient has *ROS1* fusion disease.

7. **Non-Small Cell Lung Cancer with Mesenchymal Epithelial Transition (*MET*) *M*utation.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) Patient meets ONE of the following (i or ii):
      i. Patient has non-small cell lung cancer with high level *MET* amplification; OR
      ii. Patient has non-small cell lung cancer with *MET* exon 14 skipping mutation.

CONDITIONS NOT COVERED

- **Xalkori® (crizotinib capsules and oral pellets - Pfizer)**

is(are) considered not medically necessary for ANY other use(s).

REFERENCES

1. Xalkori® capsules and oral pellets [prescribing information]. New York, NY: Pfizer; September 2023.
2. The NCCN Drugs & Biologics Compendium. © 2026 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on January 29, 2026. Search term: crizotinib.
3. The NCCN Histiocytic Neoplasms Clinical Practice Guidelines in Oncology (version 2.2025 – November 21, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on January 29, 2026.

4. The NCCN Soft Tissue Sarcoma Clinical Practice Guidelines in Oncology (version 1.2026 – January 16, 2026). © 2026 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on January 29, 2026.
5. The NCCN Uterine Neoplasms Clinical Practice Guidelines in Oncology (version 2.2026 – November 14, 2025) © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on January 29, 2026.
6. The NCCN Melanoma: Cutaneous Clinical Practice Guidelines in Oncology (version 2.2025 – January 28, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on January 29, 2026.
7. The NCCN Non-Small Cell Lung Cancer Clinical Practice Guidelines in Oncology (version 3.2026 – December 24, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on January 29, 2026.
8. The NCCN T-Cell lymphomas Clinical Practice Guidelines in Oncology (version 1.2026 – December 9, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on January 29, 2026.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Anaplastic Large Cell Lymphoma:** Added criterion that the medication can be used for palliative-intent therapy based on guideline recommendations.	01/17/2024
Annual Revision	No criteria changes.	02/05/2025
Update	04/16/2025: The policy name was changed from "Oncology – Xalkori PA Policy" to "Oncology (Oral – Anaplastic Lymphoma Kinase [ALK]-Positive Agent) – Xalkori PA Policy".	N/A
Annual Revision	**Non-Small Cell Lung Cancer – Anaplastic Lymphoma Kinase (ALK)-Positive:** The requirement that the mutation was detected by an approved test was deleted. **Non-Small Cell Lung Cancer – ROS1 Rearrangement-Positive:** The requirement that the mutation was detected by an approved test was deleted.	02/04/2026

N/A – Not applicable.