Mass General Brigham
Health Plan

Kinase Inhibitors
Cosela (trilaciclib)
Effective 09/01/2025

Plan	☒ MassHealth ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	Additional agents from this class are available through the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria.		

Overview
Cosela is indicated to decrease the incidence of chemotherapy-induced myelosuppression in adult patients when administered prior to a platinum/etoposide-containing regimen or topotecan-containing regimen for extensive-stage small cell lung cancer (ES-SCLC).

Coverage Guidelines
Authorization may be reviewed on a case by case basis for members who are new to the plan currently receiving treatment with requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs

OR

Authorization may be granted if the member meets **ALL** following criteria and documentation has been submitted:

1. Diagnosis of extensive-stage small cell lung cancer (ES-SCLC)
2. Prescriber is an oncologist
3. Appropriate dosing
4. Member is ≥ 18 years of age
5. Requested agent will be used in combination with a platinum/etoposide- or topotecan-containing regimen

Continuation of Therapy
Resubmissions should be verified for continuation of chemotherapy cycles with either a platinum/etoposide-containing regimen or a topotecan-containing regimen.

Limitations

1. Initial approvals will be granted for 6 months.
2. Reauthorizations will be granted for 3 months.

References

1. Cosela® [package insert]. Durham (NC): G1 Therapeutics, Inc.; 2023 Aug.

Review History

11/16/2022 – Reviewed and updated for Nov P&T; matched MH UPPL. Effective 11/1/22. Combined criterias: Ayvakit, Balversa, Cabometyx, Cosela, Fotivda, Gavreto, Koselugo, Lenvima, Qinlock, Retevmo, Xospata. Added drugs: Afinitor, Afinitor Disperz, Caprelsa, Cometriq, Inlyta, Nexavar, Rydapt, Sutent, Truseltiq, Votrient. Renamed policy to "Kinase Inhibitors." Updated QLs to match MH UPPL. Recent update included designating Nexavar as a brand preferred product. Effective 2/1/23. Added age limit to the Koselugo (selumetinib) for Plexiform Neurofibromas in Adult patients with Neurofibromatosis Type 1 appendix. Clarified Cosela reauthorization approval duration to 3 months. Effective 2/1/23.

01/11/2023 – Reviewed and updated for Jan P&T. Approval criteria updated for everolimus for renal angiomyolipoma with tuberous sclerosis complex (TSC), advanced pancreatic neuroendocrine tumors (PNET), advanced neuroendocrine tumors (NET) of gastrointestinal or lung origin, or subependymal giant cell astrocytoma (SEGA) with TSC- to allow appropriate specialist for the requested indication (in place of just oncology specialist). Removed step criteria of Inlyta + Keytruda for the indication of advanced RCC (clear cell histology) for Cabometyx and Lenvima approval criteria. Retevmo updated to include expanded indication of adults with locally advanced or metastatic solid tumors with a rearranged during transfection (RET) gene fusion. Ayvakit updated to require BOTH: 1) agressive SM without the D816V c-Kit mutation or with c-Kit mutation status unknown + t/f with imatinib 2) D816V c-Kit mutation positive. Several off-label indications for use of agents within this guideline moved from appendix section to Coverage Guidelines. Removed preferred status from both Inlyta and Sutent. Added 'Brand over Generic' list. Effective 3/1/23.

03/15/23 - Reviewed and updated for Mar P&T. Added Fyarro®(sirolimus injection), Hyftor®(sirolimus gel), Rezurock. Added quantity limits to Hyftor (10gm/30 days). Effective 4/1/23.

05/10/23 – Reviewed and updated for P&T. Added Lytgobi as requiring PA with same criteria as Truseltiq for the indication of treatment of adult patients with previously treated, unresectable, locally advanced or metastatic intrahepatic cholangiocarcinoma harboring fibroblast growth factor receptor 2 (FGFR2) gene fusions or other rearrangements. Criteria update on Hyftor®(sirolimus gel) to expand eligible prescriber to neurologist, and to increase quantity limit for patients < 12 years of age to 2 tubes per 30 days and increase quantity limit for patients ≥ 12 years of age to 3 tubes per 30 days. Fyarro, Lytgobi, Rezurock, Truseltiq will be approved for 6 months for initial requests. Effective 6/5/23.

12/13/23 – Reviewed and updated for P&T. Votrient will have brand preferred designation. No clinical changes. Effective 1/2/24

09/11/24 – Reviewed and updated for P&T. Separated out MBO agent (Cosela) from Kinase Inhibitor policy. Effective 10/1/24

08/13/25 – Reviewed and updated for P&T. Aligned with MH criteria in preparation for HOPA implementation. Updated references and clarified reauth criteria. Effective 9/1/25