KRAS, NRAS, and BRAF Variant Analysis and MicroRNA Expression Testing for Colorectal Cancer

Effective: March 1, 2020

Next Review: December 2020
Last Review: January 2020

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Variants in the KRAS, NRAS, and BRAF genes can substantially reduce the efficacy of certain antibody-based therapies for metastatic colon cancer. Testing for such variants can help to guide treatment decisions.

MEDICAL POLICY CRITERIA

I. **KRAS, NRAS, and BRAF** variant analysis may be considered **medically necessary** to predict nonresponse to anti-EGFR monoclonal antibodies cetuximab (Erbitux®) and panitumumab (Vectibix®) in the treatment of metastatic, unresectable, or advanced colorectal cancer.

II. **KRAS, NRAS, and BRAF** variant analysis is considered **investigational** for colorectal cancer that is not metastatic, unresectable, or advanced.

III. MicroRNA expression testing to predict anti-EGFR therapy response, including but not limited to the miR-31now™ test, is considered **investigational**.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.
LIST OF INFORMATION NEEDED FOR REVIEW

SUBMISSION OF GENETIC TESTING DOCUMENTATION

In order to determine the clinical utility of gene test(s), all of the following information must be submitted for review:

1. Name of the genetic test(s) or panel test
2. Name of the performing laboratory and/or genetic testing organization (more than one may be listed)
3. The exact gene(s) and/or mutations being tested
4. Relevant billing codes
5. Brief description of how the genetic test results will guide clinical decisions that would not otherwise be made in the absence testing
6. Medical records related to this genetic test
   - History and physical exam
   - Conventional testing and outcomes
   - Conservative treatment provided, if any

CROSS REFERENCES

2. Analysis of Human DNA in Stool Samples as a Technique for Colorectal Cancer Screening, Genetic Testing, Policy No. 12
3. Genetic and Molecular Diagnostic Testing, Genetic Testing, Policy No. 20
4. BRAF Genetic Testing To Select Melanoma or Glioma Patients for Targeted Therapy, Genetic Testing, Policy No. 41
5. Molecular Analysis for Targeted Therapy of Non-Small Cell Lung Cancer (NSCLC), Genetic Testing, Policy No. 56
6. Expanded Molecular Testing of Cancers to Select Targeted Therapies, Genetic Testing, Policy No. 83

BACKGROUND

Cetuximab (Erbitux®) and panitumumab (Vectibix®) are monoclonal antibodies that bind to the epidermal growth factor receptor (EGFR), preventing binding and activation of downstream signaling pathways vital for cancer cell proliferation, invasion, metastasis, and stimulation of neovascularization.

The KRAS gene can harbor oncogenic variants that may result in tumor resistance to therapies that target the epidermal growth factor receptor (EGFR). KRAS variants are found in approximately 30–50% of colorectal cancer tumors and are common in other tumor types.

The NRAS gene can harbor variants in codons 12, 13 and 61 that constitutively activate the EGFR-mediated signaling pathway similar to variants in KRAS. Thus, the NRAS oncogene may also have an impact on outcomes of anti-EGFR treatments for advanced colorectal cancer. Although NRAS variants account for some 15% of all RAS variants, they are rare compared to KRAS variants and are found in perhaps 2% to 7% of all CRC. As a consequence of the low prevalence of NRAS variants, it is difficult to assess their effect on cancer behavior or therapy.
BRAF encodes a protein kinase and is involved in intracellular signaling and cell growth and is a principal downstream effector of KRAS. BRAF variants occur in less than 10–15% of colorectal cancers.

It has been shown that patients with a KRAS mutant tumor do not respond to cetuximab or panitumumab. However, there are still patients with KRAS wild-type tumors that do not respond to these agents, suggesting that other factors, such as alterations in other EGFR effectors could drive resistance to anti-EGFR therapy, and therefore, BRAF variants are now increasingly being investigated in metastatic colorectal cancer. KRAS and BRAF variants are considered to be mutually exclusive.

REGULATORY STATUS

Most KRAS, NRAS, and BRAF variant and microRNA tests using PCR methodology are commercially available as laboratory-developed tests. Such tests are regulated under the Clinical Laboratory Improvement Amendments (CLIA). Premarket approval from the U.S. Food and Drug Administration (FDA) is not required when the assay is performed in a laboratory that is licensed by CLIA for high-complexity testing.

Two companion diagnostic tests for KRAS variant analysis have been premarket approval from the FDA:

- “The cobas® KRAS Mutation Test, for use with the cobas® 4800 System, [which] is a real-time PCR [polymerase chain reaction] test for the detection of seven somatic mutations in codons 12 and 13 of the KRAS gene in DNA derived from formalin-fixed paraffin-embedded human colorectal cancer (CRC) tumor tissue. The test is intended to be used as an aid in the identification of CRC patients for whom treatment with Erbitux® (cetuximab) or with Vectibix® (panitumumab) may be indicated based on a no mutation detected result.”[1]

- “The therascreen® KRAS RGQ PCR Kit is a real-time qualitative PCR assay used on the Rotor-Gene Q MDx instrument for the detection of seven somatic mutations in the human KRAS oncogene, using DNA extracted from formalin-fixed paraffin-embedded (FFPE), colorectal cancer (CRC) tissue. The therascreen® KRAS RGQ PCR Kit is intended to aid in the identification of CRC patients for treatment with Erbitux (cetuximab) and Vectibix (panitumumab) based on a KRAS no mutation detected test result.”[1]

In 2015, the FDA prescribing information for panitumumab was updated to indicate that panitumumab was not indicated for treatment in colorectal cancer patients with variants in exon 2, 3, or 4 of either KRAS or NRAS in combination with oxaliplatin-based chemotherapy.

EVIDENCE SUMMARY

Human Genome Variation Society (HGVS) nomenclature[2] is used to describe variants found in DNA and serves as an international standard. It is being implemented for genetic testing medical evidence review updates starting in 2017. According to this nomenclature, the term “variant” is used to describe a change in a DNA or protein sequence, replacing previously-used terms, such as “mutation.” Pathogenic variants are variants associated with disease, while benign variants are not. The majority of genetic changes have unknown effects on human health, and these are referred to as variants of uncertain significance.
The focus of the scientific evidence is on evidence related to the ability of test results to:

- Guide decisions in the clinical setting related to either treatment, management, or prevention, and
- Improve health outcomes as a result of those decisions.

**KRAS**

**Agency for Healthcare Research and Quality (AHRQ) Technology Assessment**

In 2010, AHRQ conducted a systematic review of the published evidence on KRAS variant testing and its ability to predict patient response to treatment with the anti-EGFR antibodies cetuximab and panitumumab. Forty-seven publications of KRAS variant testing met the eligibility criteria and were included in the review (45 in metastatic setting and two in neo-adjuvant setting). The review of evidence identified both small, retrospective studies and randomized controlled trials (RCTs). The assessment concluded that there is substantial and consistent evidence that KRAS testing can predict response to anti-EGFR therapy in colorectal cancer patients, and that,

“For all outcomes assessed, patients with KRAS mutations were less likely to experience benefit with anti-EGFR antibody treatment, compared to patients whose tumors were wild-type for KRAS mutations. The direction of the association is consistent for overall mortality, disease progression and treatment failure by radiologic imaging.”

**BlueCross BlueShield Association Technology Evaluation Center (TEC) Assessment**

The 2008 BlueCross BlueShield Association TEC Assessment concluded that the data are sufficient to demonstrate both the analytical and clinical validity of KRAS variant testing. The evidence from five randomized trials and five single-arm studies is sufficient to indicate that metastatic colorectal cancer patients with mutated KRAS tumors do not respond to anti-EGFR monoclonal antibody therapy (either as monotherapy or in combination with other treatment regimens), do not derive survival benefit, and may experience decreased progression-free survival. Identifying patients whose tumors express mutated KRAS avoids exposing them to ineffective drugs, avoids exposure to unnecessary drug toxicities, and expedites the use of the best available alternative therapy.

Several studies published after the TEC and AHRQ assessments, including a meta-analysis and systematic review, continue to support the above findings.

**NRAS**

A 2014 meta-analysis evaluated the predictive value of NRAS variants on clinical outcomes of anti-EGFR therapy in CRC and included data from three nonrandomized studies. The investigators suggest that the pooled analyses showed a trend towards poor objective response based on 17 events, but with significant effects on progression free survival (PFS) (hazard ratio [HR] 2.30, 95% CI 1.30 to 4.07) and overall survival (OS) (HR 1.85, 95% CI 1.23 to 2.78) among patients with wild-type KRAS. These results are limited by the small pool of variants, with studies reporting a prevalence of 2.2-5%.

Sorich (2015) published a systematic review and meta-analysis of nine RCTs that included 5948 metastatic colorectal cancer patients evaluated for KRAS exon 2 variants and new RAS variants, which were defined as variants in exons 3 and 4 of KRAS and exons 2, 3, and 4 of
NRAS\textsuperscript{[17]} The prevalence of NRAS exon 2, 3, and 4 variants ranged from 0.5% to 4.8% and was similar to the prevalence of KRAS exon 3 and 4 variants, which ranged from 4.3% to 6.7% of tumors. Pooled data indicated that tumors without KRAS exon 2 variants or new RAS variants were found to have significantly superior PFS (p<0.001) and OS (p=0.008) with anti-EGFR monoclonal antibody (mAb) treatment compared to tumors with these variants. In addition, there were no differences noted in the PFS or OS of tumors with KRAS exon 2 variants when compared to new RAS variants. These results were consistent between different anti-EGFR mAb agents, lines of therapy, and chemotherapy. No PFS or OS benefit was observed with the use of anti-EGFR mAb agents in tumors with KRAS exon 2 variants or new RAS variants (p>0.05). Based on these results, authors concluded that approximately 53% of metastatic colorectal tumors (~42% with KRAS exon 2 and ~11% with new RAS variants) are unlikely to have a positive response to anti-EGFR mAb therapy. Results from this pooled data analysis suggest NRAS variant results may be used to guide treatment decisions in patients with metastatic colorectal tumors, as patients with NRAS variants are unlikely to benefit from anti-EGFR mAb therapy.

A systematic review and meta-analysis by Lin (2016) evaluated the efficacy of cetuximab-based chemotherapy according to RAS and BRAF variant subgroups in nine studies.\textsuperscript{[12]} Cetuximab was associated with longer overall survival in tumors that had no variants in exon 2 of KRAS (p=0.004), tumors with wild-type (exons 2, 3, and 4) KRAS/NRAS (p=0.0002). There were no significant differences in OS or PFS between tumors with KRAS exon 2 variants and other exon 2, 3, or 4 KRAS or NRAS variants.

Additional studies published since the systematic reviews have shown similar differences in response to EGFR inhibitors according to RAS variant status.\textsuperscript{[18]}

BRAF

Systematic Reviews

Pietrantonio (2015) published a systematic review and meta-analysis of randomized trials that compared cetuximab or panitumumab plus chemotherapy compared to standard therapy or best supportive care in patients with advanced colorectal cancer that have a BRAF variant.\textsuperscript{[19]} Pooled results were reported for the efficacy of anti-EGFR-based therapy according to variant status as a first-line, second-line or refractory setting. Nine phase III trials and one phase II trial with a total of 463 patients with metastatic colon cancer were analyzed. Treatment with cetuximab or panitumumab did not significantly improve PFS (HR 0.88, 95% CI 0.67 to 1.14), OS (HR 0.91, 95% CI 0.62 to 1.34), or overall response rates (RR 1.31, 95% CI 0.83 to 2.08) compared to the control groups.

Rowland (2015) also published a systematic review and meta-analysis RCTs which evaluated the impact of BRAF variant status upon anti-EGFR mAb treatment outcomes in patients with metastatic colorectal cancer.\textsuperscript{[20]} Seven RCTs met inclusion criteria for OS and eight studies met inclusion criteria for PFS. Pooled data indicated that cetuximab and panitumumab did not improve PFS (HR 0.86, 95% CI 0.61 to 1.21) or OS (HR 0.97, 95% CI 0.67 to 1.41) in patients with BRAF variants.

Other Studies

An updated analysis of the CRYSTAL trial reported increased follow-up time and an increased number of patients evaluable for tumor KRAS status and considered the clinical significance of
The tumor variant status of \textit{BRAF} in the expanded population of patients with \textit{KRAS} wild-type tumors.\cite{8} The impact of \textit{BRAF} tumor variant status in relation to the efficacy of the chemotherapy regimen consisting of cetuximab plus folinic acid (leucovorin), 5-FU, and irinotecan (FOLFIRI) was examined in the population of patients with \textit{KRAS} wild-type disease (n=625). There was no evidence of an independent treatment interaction by tumor \textit{BRAF} variant status. The authors concluded that \textit{BRAF} variant status was not predictive of treatment effects of cetuximab plus FOLFIRI but that \textit{BRAF} tumor variant was a strong indicator of poor prognosis for all efficacy end points compared with those whose tumors were wild-type. Other studies have been published that report mixed results.\cite{8,21-29}

The data regarding the utility of variant testing as a predictive marker which informs the use of anti-EGFR mAb is less substantial for \textit{BRAF} testing than for \textit{KRAS} or \textit{NRAS} testing. However, the evidence suggests that \textit{BRAF} variant testing may be useful in directing treatment decisions, as anti-EGFR therapies do not improve PFS or OS in metastatic colorectal cancer patients with \textit{BRAF} variants.

\textbf{MICRORNA}

Several studies have evaluated the association between the expression of the miR-31-3p microRNA and colorectal cancer progression in patients treated with anti-EGFR therapies.\cite{30-34} For example, an industry-sponsored study published by Laurent-Puig (2018) reported that individuals with low miR-31-3p expression derived more benefit from cetuximab than bevacizumab (PFS HR 0.74, 95% CI 0.55 to 1.00, p=0.05; OS HR 0.61, 95% CI 0.41 to 0.88, p<0.01).\cite{30} However, no studies have assessed the use of microRNA expression test results to guide treatment decisions or impact health outcomes.

\textbf{PRACTICE GUIDELINE SUMMARY}

\textbf{NATIONAL COMPREHENSIVE CANCER NETWORK}

The National Comprehensive Cancer Network (NCCN)\cite{35} guidelines (version 1.2020) on the treatment of colon cancer make the following recommendation regarding \textit{KRAS}, \textit{NRAS}, and \textit{BRAF} variant testing:

“\textit{All patients with metastatic colorectal cancer should have tumor tissue genotyped for RAS (\textit{KRAS} and \textit{NRAS}) and \textit{BRAF} mutations individually or as part of an NGS panel. Patients with any known \textit{KRAS} mutation (exon 2, 3, 4) or \textit{NRAS} mutation (exon 2, 3, 4) should not be treated with either cetuximab or panitumumab. \textit{BRAF} V600E mutation makes response to panitumumab or cetuximab highly unlikely unless given with a \textit{BRAF} inhibitor.}”

The guidelines did not discuss microRNA testing.

\textbf{SUMMARY}

There is enough evidence to show that cetuximab and panitumumab are not effective treatments for colorectal cancers with \textit{KRAS}, \textit{NRAS} or \textit{BRAF} variants. Clinical guidelines based on research recommend testing patients with metastatic colorectal cancer for variants in the \textit{KRAS}, \textit{NRAS}, and \textit{BRAF} genes to help with treatment decisions. Therefore, \textit{KRAS}, \textit{NRAS} and \textit{BRAF} variant analysis may be considered medically necessary to predict
nonresponse to anti-EGFR monoclonal antibodies in the treatment of metastatic colorectal cancer.

Anti-EGFR monoclonal antibodies are approved to treat advanced forms of colorectal cancer. These therapies are not approved for patients with non-metastatic, resectable colorectal cancer. Therefore, KRAS, NRAS, and BRAF variant analysis is considered investigational for colorectal cancer that is not metastatic, unresectable, or advanced.

There is not enough research to show that testing for microRNA expression can improve treatment decisions or health outcomes for patients with colorectal cancer. In addition, there are no clinical guidelines based on research that recommend microRNA testing for these patients. Therefore, microRNA expression testing to predict anti-EGFR therapy response, including but not limited to the miR-31now™ test, is considered investigational.

REFERENCES


### CODES

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