Clinical Policy: Durvalumab (Imfinzi)

Reference Number: CP.PHAR.339
Effective Date: 07.01.17
Last Review Date: 05.18
Line of Business: Medicaid, HIM-Medical Benefit

Coding Implications
Revision Log

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

Description

Durvalumab (Imfinzi®) is a programmed death-ligand 1 (PD-L1) blocking antibody.

FDA Approved Indication(s)

Imfinzi is indicated for the treatment of patients with:

- Locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy or who have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.
  - This indication is approved under accelerated approval based on tumor response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.
- Unresectable, Stage III non-small cell lung cancer (NSCLC) whose disease has not progressed following concurrent platinum-based chemotherapy and radiation therapy.

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 Imfinzi is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Urothelial Carcinoma (must meet all)**:**

1. Diagnosis of locally advanced or metastatic (Stage IV) urothelial carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Failure of or disease progression on platinum-containing chemotherapy;
4. Dose does not exceed 10 mg/kg every 2 weeks.

Approval duration: 6 months

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

1. Diagnosis of unresectable (Stage III) NSCLC;
2. Prescribed by or in consultation with an oncologist;
3. Disease has not progressed following concurrent platinum-based chemotherapy and radiation therapy;
4. Dose does not exceed 10 mg/kg every 2 weeks.

Approval duration: 6 months

C. Other diagnoses/indications:

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Currently receiving medication via Centene benefit, or member has previously met initial approval criteria, or documentation supports that member is currently receiving Imfinzi for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. Dose does not exceed 10 mg/kg every 2 weeks.

Approval duration:
NSCLC: up to a total duration of 12 months
All other indications: 12 months

B. Other diagnoses/indications:

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 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 – HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
NSCLC: non-small cell lung cancer
RT: radiotherapy

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Urothelial Carcinoma		

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
DDMVAC (dose-dense methotrexate, vinblastine, doxorubicin, and cisplatin)	Varies	Varies
gemcitabine with cisplatin	Varies	Varies
CMV (cisplatin, methotrexate, and vinblastine)	Varies	Varies
NSCLC		
cisplatin with concurrent radiotherapy (RT)	Varies	Varies
carboplatin with concurrent RT	Varies	Varies
paclitaxel with concurrent RT	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Urothelial carcinoma, NSCLC	10 mg/kg IV infusion over 60 minutes every 2 weeks	10 mg/kg per 2 weeks

VI. Product Availability

Injection: 120 mg/2.4 mL, 500 mg/10 mL solution in a single-dose vial

VII. References

1. Imfinzi Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; February 2018. Available at: https://www.imfinzi.com. Accessed February 27, 2018.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed February 6, 2018.
3. National Comprehensive Cancer Network. Bladder Cancer Version 2.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/bladder.pdf. Accessed February 27, 2018.
4. National Comprehensive Cancer Network. Non-Small Cell Lung Cancer Version 3.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed April 18, 2018.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9999	Injection, not otherwise classified, antineoplastic drugs
C9492	Injection, durvalumab, 10 mg

Reviews, Revisions, and Approvals	Date	P& T Approval Date
Policy created	06.17	07.17
2Q 2018 annual review: added new FDA indication for NSCLC with total duration of therapy of 12 months only per trial design and NCCN guideline; HIM added; references reviewed and updated.	04.24.18	05.18

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.