

## Policy and Procedure

<b>PHARMACY PRIOR AUTHORIZATION POLICY AND CRITERIA ORPTCONC102.1223</b>	<b>ANTINEOPLASTIC AGENTS INJECTABLE ANTI-CANCER MEDICATIONS</b>  See <a href="#">Appendix A</a> for Medications covered by policy
<b>Effective Date: 03/1/2024</b>	<b>Review/Revised Date:</b> 04/16, 07/16, 12/16, 01/17, 08/17, 12/17, 04/18, 12/18, 01/19, 08/19, 01/20, 06/20, 07/20, 09/20, 12/20, 01/21, 03/21, 05/21, 08/21, 10/21, 12/21, 01/22, 04/22, 05/22, 08/22, 01/23, 04/23, 08/23, 10/23, 11/23 (JLS)
<b>Original Effective Date: 10/16</b>	<b>P&amp;T Committee Meeting Date:</b> 04/16, 08/16, 02/16, 02/17, 06/17, 08/17, 10/17, 02/18, 04/18, 12/18, 02/19, 06/19, 08/19, 10/19, 12/19, 02/20, 04/20, 06/20, 08/20, 10/20, 12/20, 02/21, 04/21, 06/21, 12/21, 02/22, 04/22, 06/22, 08/22, 10/22, 12/22, 02/23, 06/23, 08/23, 10/23, 12/23
<b>Approved by: Oregon Region Pharmacy and Therapeutics Committee</b>	
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### SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Aycin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

### APPLIES TO:

Commercial  
Medicaid

### POLICY CRITERIA:

#### COVERED USES:

All Food and Drug Administration (FDA) approved indications not otherwise excluded from the benefit.

For off-label use criteria, please see the Chemotherapy Treatment Utilization Criteria; Coverage for Non-FDA Approved Indications ORPTCOPS105.

For bevacizumab given via intravitreal injection: See payment policy [97.0 Compound Drugs Administered in the Physician's Office](#)

#### REQUIRED MEDICAL INFORMATION:

For initial authorization:

1. Use must be for an FDA approved indication or indication supported by National Comprehensive Cancer Network guidelines with recommendation 2A or higher
2. For requests for trastuzumab or bevacizumab: Documented trial and failure, intolerance, or contraindication to the use of both preferred biosimilar medications, as follows:
  - a. Trastuzumab preferred products: Ogivri® (trastuzumab-dkst) and Trazimera® (trastuzumab-qyyp)

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- b. Bevacizumab preferred products: Mvasi® (bevacizumab-bvzr) and Zirabev® (bevacizumab-awwb)

For patients established on therapy: documentation of adequate response to the medication must be provided.

**EXCLUSION CRITERIA:** N/A

**AGE RESTRICTIONS:** N/A

**PRESCRIBER RESTRICTIONS:**

Must be prescribed by, or in consultation with an oncologist

**COVERAGE DURATION:**

Authorization will be approved until no longer eligible with the plan, subject to formulary and/or benefit changes.

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*For off-label use criteria please see the Chemotherapy Treatment Utilization Criteria; Coverage for Non-FDA Approved Indications ORPTCOPS105.*

*Requests for indications that were approved by the FDA within the previous six (6) months may not have been reviewed by the health plan for safety and effectiveness and inclusion on this policy document. These requests will be reviewed using the New Drug and or Indication Awaiting P&T Review; Prior Authorization Request ORPTCOPS047.*

*Requests for a non-FDA approved (off-label) indication requires the proposed indication be listed in either the American Hospital Formulary System (AHFS), Drugdex, or the National Comprehensive Cancer Network (NCCN) and is considered subject to evaluation of the prescriber's medical rationale, formulary alternatives, the available published evidence-based research and whether the proposed use is determined to be experimental/investigational.*

*Coverage for Medicaid is limited to a condition that has been designated a covered line item number by the Oregon Health Services Commission listed on the Prioritized List of Health Care Services.*

*Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.*

**INTRODUCTION:**

Medications used in the treatment of cancer pose a risk for serious side effects; their efficacy is indeterminate outside of indications for which clinical trial evidence available. Additionally, many medications to treat cancer are high in cost. Prior authorization review of oncology medication allows for an assessment of safety and efficacy data for medication(s) requested for a member.

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**FDA APPROVED INDICATIONS:**

Refer to Micromedex® for FDA approved indications of individual medications.

**POSITION STATEMENT:**

Use of oncology medications outside of the FDA approved indication may be supported by clinical trial data. National Comprehensive Cancer Network (NCCN) provides evidence-based Clinical Practice Guidelines in Oncology (NCCN Guidelines®) steered by consensus from a panel of subspecialists. FDA labeled and non-FDA approved indications are included. Guidelines are reviewed annually and updated as new data becomes available. The NCCN Drugs & Biologics Compendium (NCCN Compendium®), based directly on NCCN Guidelines®, lists indications for each individual medication for which there is a recommendation for use, with the category of recommendation (see description below) included. The NCCN Guidelines® and NCCN Compendium® are intended to aid clinicians and payers in decisions regarding treatment of cancer.

**National Comprehensive Cancer Network (NCCN) Categories for Recommendations**

	Description of Evidence and Consensus
Category 1	Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2A	Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2B	Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
Category 3	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate

The NCCN Compendium® is one reference utilized in Providence Health Plan's coverage determination process, based on the operational policy: Chemotherapy Treatment Utilization Criteria; Coverage for Non-FDA Approved Indications ORPTCOPS105.

**Biosimilar Products**

A biosimilar is a type of biologic drug that is highly similar to an FDA-approved biologic drug, known as the reference product. Biosimilars provide equivalent clinical benefit to the original reference product ("therapeutically equivalent"). These products have been deemed interchangeable with the reference products by the Oregon Region Pharmacy & Therapeutics Committee (ORPTC). Members will be required to utilize a preferred biosimilar, unless clinical documentation is provided

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outlining medical rationale for using a non-preferred product, as outlined in the criteria above.

**REFERENCE/RESOURCES:**

1. About the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). [https://www.nccn.org/professionals/physician\\_gls/default.aspx](https://www.nccn.org/professionals/physician_gls/default.aspx) Accessed January 13, 2022.
2. NCCN. Development and Update of Guidelines. <https://www.nccn.org/guidelines/guidelines-process/development-and-update-of-guidelines> Accessed January 5, 2023.
3. Micromedex: DRUGDEX® System [Internet database]. Greenwood Village, CO: Thomson Reuters (Healthcare) Inc.; Updated periodically.

APPENDIX A

Medication Brand Name	Generic Name	HCPCS Code
<b>Bevacizumab</b>		
<i>Preferred products</i>		
Mvasi®	bevacizumab-awwb	Q5107
Zirabev®	bevacizumab-bvzr	Q5118
<i>Non-preferred products</i>		
Alymsys®	bevacizumab-maly	Q5126
Avastin®	bevacizumab	J9035
Vegzelma®	bevacizumab-adcd	Q5129
<b>Trastuzumab</b>		
<i>Preferred products</i>		
Ogivri®	trastuzumab-dkst	Q5114
Trazimera®	trastuzumab-gyyp	Q5116
<i>Non-preferred products</i>		
Herceptin®	trastuzumab	J9355
Herceptin Hylecta®	trastuzumab and hyaluronidase-oysk	J9356
Herzuma®	trastuzumab-pkrb	Q5113
Kanjinti	trastuzumab-anns	Q5117

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Ontruzant®	trastuzumab-dttb	Q5112
<b>All other medications covered by policy</b>		
Abraxane®	paclitaxel, albumin bound	J9264
Adcetris®	brentuximab vedotin	J9042
Adstiladrin®	nadofaragene firadenovec-vncg	J9029
Aliqopa®	copanlisib	J9057
Alkeran®	melphalan	J9245
Arranon®	nelarabine	J9261
Azzurra®	ofatumumab	J9302
Asparlas®	calaspargase pegol-mknl	J9118
Azedra®	lobenguane iodine-131	A9590
Bavencio®	avelumab	J9023
Beleodaq®	belinostat	J9032
Belrapzo®	bendamustine HCl	J9036
Bendamustine HCl	bendamustine HCl	J9058
Bendeka®	bendamustine	J9034
Besponsa®	inotuzumab ozogamicin	J9229
Besremi®	ropeginterferon Alfa-2b-njft *self-administered	J3590
Blenrep®	belantamab mafodotin-blmf	J9037
Blincyto®	blinatumomab	J9039
Columvi®	glofitamab-gxbm	J9999 C9399
Cosela®	trilaciclib dihydrochloride	J1448
Cyramza®	ramucirumab	J9308
Dacogen®	decitabine	J0893/J0894
Danyelza®	naxitamab-gqgk	J9348
Darzalex Faspro®	daratumumab and hyaluronidase-fihj	J9144
Darzalex™	daratumumab	J9145
Elahere®	mirvetuximab soravtansine-gynx	J9063
Elzonris®	tagraxofusp-erzs	J9269

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Empliciti®	elotuzumab lyophilized	J9176
Enhertu® (not interchangeable with other trastuzumab products)	fam-trastuzumab deruxtecan-nxki	J9358
Epkinly®	epcoritamab-bysp	J9999
Erbix®	cetuximab	J9055
Evomela	melphalan hcl/betadex sulfobutyl ether sodium	J9246
Faslodex®	fulvestrant	J9393/J9394/J9395
Foloty®	pralatrexate	J9307
Fyarro®	sirolimus protein-bound	J9331/J9999
Halaven®	eribulin mesylate	J9179
Imfinzi®	durvalumab	J9173
Imjudo®	tremelimumab-actl	J9347
Imlygic®	talimogene laherparepvec for intralesional injection	J9325
Istodax®	romidepsin	J9315
Ixempra®	ixabepilone	J9207
Jelmyto®	mitomycin pyelocalyceal solution	J9281
Jemperli®	dostarlimab	J9272
Jevtana®	cabazitaxel	J9043
Kadcyla® (not interchangeable with other trastuzumab products)	ado-trastuzumab emtansine	J9354
Keytruda®	pembrolizumab	J9271
Kimmtrak®	tebentafusp-tebn	J9274
Kyprolis®	carfilzomib	J9047
Libtayo®	cemiplimab-rwlc	J9119
Lumoxiti®	moxetumomab pasudotox-tdfk	J9313
Lunsumio®	mosunetuzumab-axgb	J9350
Lutathera®	lutetium lu <sup>177</sup> dotatate	A9513

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Margenza®	margetuximab-cmkb	J9353
Monjuvi®	tafasitamab-cxix	J9349
Mylotarg®	gemtuzumab ozogamicin	J9203
Onivyde®	liposomal irinotecan	J9205
Opdivo®	nivolumab	J9299
Opdualag®	nivolumab/relatilimab-RMBW	J9298
Padcev®	enfortumab vedotin-ejfv	J9177
Pedmark®	sodium thiosulfate	J0208
Pepaxto®	melphalan flufenamide	J9247
Perjeta®	pertuzumab	J9306
Phesgo®	pertuzumab, trastuzumab, hyaluronidase-zzxf	J9316
Pluvicto®	lutetium lu-177 vipivotide tetraxetan	A9607
Polivy®	polatuzumab vedotin-piiq	J9309
Portrazza®	necitumumab	J9295
Poteligeo®	mogamulizumab-kpkc	J9204
Rybrevant®	amibantamab	J9021
Rylaze®	asparaginase erwinia chrysanthemi (recombinant)-rywn)	
Sarclisa®	isatuximab	J9227
Synribo®	omacetaxine subcutaneous injection	J9262
Tecentriq®	atezolizumab	J9022
Temodar® IV	temozolomide	J9328
Tivdak®	tisotumab vedotin-tftv	J9273
Torisel®	temsirolimus	J9330
Treanda®	bendamustine	J9033
Trodelyv®	sacituzumab govitecan-hziy	J9317
Vectibix®	panitumumab	J9303
Velcade®	bortezomib	J9041, J9046, J9048, J9049
Vidaza®	azacitidine	J9025
Vivimusta	bendamustine HCl	J9056

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Vyxeos®	daunorubicin/cytarabine liposomal	J9153
Xofigo®	radium-223	A9606
Yervoy®	ipilimumab	J9228
Yondelis®	trabectedin	J9352
Zaltrap®	ziv-aflibercept	J9400
Zepzelca®	lurbinectedin	J9223
Zynlonta®	loncastuximab tesirine	J9359
Zynyz®	retifanlimab-dlwr	J9999