

# Pharmacy Management Drug Policy

**SUBJECT:** Immune Checkpoint Inhibitor Clinical Review Prior Authorization (CRPA)

**POLICY NUMBER:** PHARMACY-96

**EFFECTIVE DATE:** 12/2020

**LAST REVIEW DATE:** 08/03/2026

*If the member's subscriber contract excludes coverage for a specific service or prescription drug, it is not covered under that contract. In such cases, medical or drug policy criteria are not applied. This drug policy applies to the following line/s of business:*

## Policy Application

|                  |                                                                                     |                                                             |
|------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <b>Category:</b> | <input checked="" type="checkbox"/> Commercial Group (e.g., EPO, HMO, POS, PPO)     | <input checked="" type="checkbox"/> Medicare Advantage      |
|                  | <input checked="" type="checkbox"/> On Exchange Qualified Health Plans (QHP)        | <input type="checkbox"/> Medicare Part D                    |
|                  | <input checked="" type="checkbox"/> Off Exchange Direct Pay                         | <input checked="" type="checkbox"/> Essential Plan (EP)     |
|                  | <input checked="" type="checkbox"/> Medicaid & Health and Recovery Plans (MMC/HARP) | <input checked="" type="checkbox"/> Child Health Plus (CHP) |
|                  | <input type="checkbox"/> Federal Employee Program (FEP)                             | <input type="checkbox"/> Ancillary Services                 |
|                  | <input checked="" type="checkbox"/> Dual Eligible Special Needs Plan (D-SNP)        |                                                             |

## DESCRIPTION:

This policy contains the coverage criteria for oncologic Immune Checkpoint Inhibitors. The Immune Checkpoint Inhibitors include programmed cell death 1 (PD-1) inhibitors, programmed death-ligand 1 (PD-L1) inhibitors, cytotoxic T-lymphocyte-associated protein 4 (CTLA-4) inhibitors, and lymphocyte-activation gene 3 (LAG-3) blockers.

Keytruda (pembrolizumab), Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph), Opdivo (nivolumab), Opdivo Qvantig (nivolumab and hyaluronidase- nvhy), Libtayo (cemiplimab), Loqtorzi (toripalimab-tpzi), Jemperli (dostarlimab-gxly), Tevimbra (tisnelizumab-jsgr) and Zynyz (retifanlimab-dlwr) are all PD-1 blocking antibodies. PD-L1 blocking antibodies include Tecentriq (atezolizumab), Tecentriq Hybreza (atezolizumab and hyaluronidase- tqjs), Bavencio (avelumab), Imfinzi (durvalumab) and Unloxcyt (cosibelimab). Yervoy (ipilimumab) and Imjudo (tremelimumab-actl) are CTLA-4 blocking antibodies, CTLA-4 blocking antibodies often used in combination with other Immune Checkpoint Inhibitors. Opdualag (nivolumab/relatlimab-rmbw) is fixed-dose combination product containing nivolumab (a PD-1 blocker) and relatlimab-rmbw (a novel LAG-3 blocker).

Immune checkpoint inhibitors work by blocking certain receptors (either PD-1 [present on T cells] or CTLA-4 [present on T cells]) or ligands (PD-L1 [present on tumor cells]) resulting in an enhanced antitumor immune response.

The Immune Checkpoint Inhibitors Clinical Review Prior-Authorization (CRPA) process is designed to ensure that newly approved (FDA) prescription drugs are used appropriately in cases where a drug poses potential efficacy, quality, toxicity, or utilization concerns for the members and the Health Plan. In addition, this policy may be used for medications that have significant concerns about safety or inappropriate use, but do not warrant a stand-alone policy. The Pharmacy Management clinical team reviews the Immune Checkpoint Inhibitors falling into these categories under the process of Clinical Review Prior Authorization (CRPA). A Letter of Medical Necessity (LOMN), Exception Form, or Prior Authorization Form completion is required for consideration of drug coverage under this policy.

Prior Authorization criteria listed in this policy is based on FDA labeled indication or NCCN level of evidence 1 or 2A. For requests that do not meet the policy criteria defined below, please refer to the Off-Label Use of FDA Approved Drugs policy.

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### **POLICY GUIDELINES:**

1. This policy is subject to frequent revisions as new medications come onto the market. Some drugs will require prior authorization prior to approve language being added to the policy.
2. Supportive documentation of previous drug use must be submitted for any criteria which require trial of a preferred agent if the preferred drug is not found in claims history.
3. Clinical documentation must be submitted for each request (initial and recertification). Supporting clinical documentation includes but is not limited to progress notes documenting previous treatments/treatment history, laboratory test results, genetic testing/biomarker test results, and imaging.
4. Dose and frequency should be consistent with FDA labeling, NCCN Compendia, or Indication Specific Peer-Reviewed Literature. When the dose and/or frequency is requested in excess of established parameters, the request may be subject to an off-label review for medical necessity.
5. Not all contracts cover all Medical Infusible drugs. Refer to specific contract/benefit plan language for exclusions of Injectable Medications.
6. For contracts where Insurance Law § 4903(c-1), and Public Health Law § 4903(3-a) are applicable, if trial of preferred drug(s) is the only criterion that is not met for a given condition, and one of the following circumstances can be substantiated by the requesting provider, then trial of the preferred drug(s) will not be required.
  - The required prescription drug(s) is (are) contraindicated or will likely cause an adverse reaction or physical or mental harm to the member;
  - The required prescription drug is expected to be ineffective based on the known clinical history and conditions and concurrent drug regimen;
  - The required prescription drug(s) was (were) previously tried while under the current or a previous health plan, or another prescription drug or drugs in the same pharmacologic class or with the same mechanism of action was (were) previously tried and such prescription drug(s) was (were) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
  - The required prescription drug(s) is (are) not in the patient's best interest because it will likely cause a significant barrier to adherence to or compliance with the plan of care, will likely worsen a comorbid condition, or will likely decrease the ability to achieve or maintain reasonable functional ability in performing daily activities;
  - The individual is stable on the requested prescription drug. The medical profile of the individual (age, disease state, comorbidities), along with the rationale for deeming stability as it relates to standard medical practice and evidence-based practice protocols for the disease state will be taken into consideration.
  - The above criteria are not applicable to requests for brand name medications that have an AB rated generic. We can require a trial of an AB-rated generic equivalent prior to providing coverage for the equivalent brand name prescription drug.
7. Unless otherwise stated below within the Drug Specific Criteria (TABLE 4), approval time periods are listed in TABLE 1 below
  - a. Continued approval at time of recertification will require documentation that the drug is providing ongoing benefit to the patient in terms of improvement or stability in disease state or condition. Such documentation may include progress notes, imaging or laboratory findings, and other objective or subjective measures of benefit which support that continued use of the requested product is medically necessary. Also, ongoing use of the requested product must continue to reflect the current policy's preferred formulary [Recertification reviews may result in the requirement to try more cost-effective treatment alternatives as they become available (i.e., generics, biosimilars, or other guideline-supported treatment options)]

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and the requested dose must continue to meet FDA approved or off-label/guideline supported dosing

- b. Recertifications will be evaluated for the regimen that is currently being prescribed (monotherapy, combination therapy, etc.). If this differs from the initial review, the request will be reviewed based on the level of evidence that is available for the current regimen.
8. This policy does not apply to Medicare Part D and D-SNP pharmacy benefits. The drugs in this policy may apply to all other lines of business including Medicare Advantage.
9. For members with Medicare Advantage, medications with a National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) will be covered pursuant to the criteria outlined by the NCD and/or LCD. NCDs/LCDs for applicable medications can be found on the CMS website at <https://www.cms.gov/medicare-coverage-database/search.aspx>. Indications that have not been addressed by the applicable medication's LCD/NCD will be covered in accordance with criteria determined by the Health Plan (which may include review per the Health Plan's Off- Label Use of FDA Approved Drugs policy). Step therapy requirements may be imposed in addition to LCD/NCD requirements.
10. Unless otherwise explicitly stated in the NCCN compendia, the use of an immune checkpoint inhibitor therapy following disease progression on prior immune checkpoint inhibitor therapy is considered experimental and investigational and will be subject to an off-label review
11. Unless otherwise indicated within drug specific criteria, the drugs listed in this policy are administered by a healthcare professional and therefore are covered under the medical benefit.
12. Preferred product requirements do not apply to Medicare Advantage plans
13. All requests will be reviewed to ensure they are being used for an appropriate indication and may be subject to an off-label review in accordance with our Off-Label Use of FDA Approved Drugs Policy (Pharmacy-32). This includes any request that is made for drug(s) that was (were) previously tried (including in the same pharmacologic class or with the same mechanism of action) and such drug(s) was (were) discontinued due to a lack of efficacy.
14. All utilization management requirements outlined in this policy are compliant with applicable New York State insurance laws and regulations. Policies will be reviewed and updated as necessary to ensure ongoing compliance with all state and federally mandated coverage requirements.
15. Manufacturers may either discontinue participation in, or may not participate in, the Medicaid Drug Rebate Program (MDRP). Under New York State Medicaid requirements, physician-administered drugs must be produced by manufacturers that participate in the MDRP. Products made by manufacturers that do not participate in the MDRP will not be covered under Medicaid Managed Care/HARP lines of business. Drug coverage will not be available for any product from a non-participating manufacturer. For a complete list of New/Reinstated & Terminated Labelers please visit: <https://www.medicaid.gov/medicaid/prescriptiondrugs/medicaid-drug-rebate-program/newreinstated-terminated-labeler-information/index.html>

**TABLE 1. APPROVAL TIME PERIODS:**

| Line of Business                                                             | Initial approval | Continued approval |
|------------------------------------------------------------------------------|------------------|--------------------|
| Commercial, Exchange, and SafetyNet<br>(Medicaid, HARP, CHP, Essential Plan) | 6 months         | 6 months           |
| Medicare Part B                                                              | 6 months         | 6 months           |

**TABLE 2. IMMUNE CHECKPOINT INHIBITOR DRUGS INCLUDED IN THIS POLICY:**

| Drug name (generic name) | HCPCS |
|--------------------------|-------|
| Bavencio (avelumab)      | J9023 |
| Imfinzi (durvalumab)     | J9173 |

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|---------------------------------------------------------------|-------|
| Imjudo (tremelimumab-actl)                                    | J9347 |
| Jemperli (dostarlimab-gxly)                                   | J9272 |
| Keytruda (pembrolizumab)                                      | J9271 |
| Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) | J9277 |
| Libtayo (cemiplimab-rwlc)                                     | J9119 |
| Loqtorzi (toripalimab-tpzi)                                   | J3263 |
| Opdivo (nivolumab)                                            | J9299 |
| Opdivo Qvantig (nivolumab and hyaluronidase-nvhy)             | J9289 |
| Opdualag (nivolumab/relatlimab-rmbw)                          | J9298 |
| Tecentriq (atezolizumab)                                      | J9022 |
| Tecentriq Hybreza (atezolizumab and hyaluronidase-tqjs)       | J9024 |
| Tevimbra (tislelizumab-jsgr)                                  | J9329 |
| Unloxcyt (cosibelimab-ipdl)                                   | J9275 |
| Yervoy (ipilimumab)                                           | J9228 |
| Zynyz (retifanlimab-dlwr)                                     | J9345 |

**TABLE 3. DRUGS WITH MAXIMUM DURATION OF THERAPY BASED ON DIAGNOSIS:**

| Drug Name                          | Diagnosis                                                                                                                                         | Maximum Duration of Therapy (Months/Years, Cycles, Doses)                                 |
|------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| <b>Imfinzi (durvalumab)</b>        | Adjuvant treatment of resectable NSCLC                                                                                                            | Max of 12 cycles                                                                          |
|                                    | Unresectable Stage III NSCLC                                                                                                                      | Max of 12 months                                                                          |
|                                    | Limited-stage SCLC                                                                                                                                | Max of 24 months                                                                          |
|                                    | BCG-Naïve, High-Risk NMIBC                                                                                                                        | Max of 13 cycles                                                                          |
| <b>Loqtorzi (toripalimab-tpzi)</b> | Metastatic or recurrent, locally advanced nasopharyngeal carcinoma (in combination with cisplatin and gemcitabine)                                | Max of 2 years                                                                            |
| <b>Yervoy (ipilimumab)</b>         | Unresectable or metastatic melanoma                                                                                                               | Max of 4 Doses                                                                            |
|                                    | Adjuvant treatment of melanoma                                                                                                                    | Max of 4 Doses if given every 3 weeks <b>OR</b><br>Max of 3 years if given every 12 weeks |
|                                    | Unresectable or metastatic melanoma (in combination with nivolumab [Opdivo])                                                                      | Max of 4 Doses                                                                            |
|                                    | Advanced renal cell carcinoma (in combination with nivolumab [Opdivo])                                                                            | Max of 4 Doses                                                                            |
|                                    | Microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) metastatic colorectal cancer (in combination with nivolumab [Opdivo]) | Max of 4 Doses                                                                            |
|                                    | Hepatocellular carcinoma (in combination with nivolumab [Opdivo])                                                                                 | Max of 4 Doses                                                                            |

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|  | Metastatic non-small cell lung cancer expressing PD-L1 (in combination with nivolumab [Opdivo]) | Max of 2 years |
|  | Metastatic or recurrent non-small cell lung cancer (in combination with nivolumab [Opdivo])     | Max of 2 years |
|  | Malignant pleural mesothelioma (in combination with nivolumab [Opdivo])                         | Max of 2 years |
|  | Esophageal squamous cell carcinoma (in combination with nivolumab [Opdivo])                     | Max of 2 years |

#### **UNIVERSAL CRITERIA:**

The drugs listed in this policy will be reviewed in accordance with criteria described below.

Please note select drugs are subject to additional and/or more comprehensive coverage criteria which can be found in the Drug Specific Criteria table:

1. Must prescribed by, or in consultation with an Oncologist, Hematologist, or appropriate specialist **AND**
2. Must have a diagnosis that meets **one** of the following:
  - a. Approved by the U.S. Food and Drug Administration (FDA) **OR**
  - b. A National Comprehensive Cancer Network (NCCN) category level 1 or 2A recommendation **OR**
  - c. Satisfied by the criteria required for the applicable line of business (LOB) for the treatment of cancer in the Off-Label Use of FDA Approved Drugs policy (Pharmacy-32) **AND**
3. Step therapy requirements must be met for select drugs (see TABLE 5)

#### **TABLE 4. DRUG SPECIFIC CRITERIA:**

Drug specific criteria may include but is not limited to unique approval timeframes, step therapy requirements, and additional limitations to universal coverage criteria

#### **TABLE 5. DRUGS WITH STEP THERAPY REQUIREMENTS:**

- Applies to New Starts ONLY
- Step Therapy criteria listed below applies to all *shared* FDA labeled or compendia supported *indications/regimens*, defined as NCCN level of evidence 1 or 2A.
- Adequate medical justification includes but is not limited to a contraindication to the preferred product or intolerable side-effects that occurred while on therapy. Use of a non-preferred drug will still be considered appropriate for its FDA approved indication or NCCN compendia supported use if there is lack of disease progression following a trial of a preferred product.

| Drug Name                      | Diagnosis                                           | Requirement                                                                                                                                                     |
|--------------------------------|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Bavencio<br/>(avelumab)</b> | metastatic Merkel Cell Carcinoma                    | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) cannot be used |
|                                | locally advanced or metastatic Urothelial Carcinoma | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex                                                                |

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|----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                                                                                                                                                                                               | (pembrolizumab and berahyaluronidase alfa-pmph) cannot be used                                                                                                                               |
|                                        | advanced Renal Cell Carcinoma (RCC)                                                                                                                                                                           | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) cannot be used                              |
|                                        | for Gestational Trophoblastic Neoplasia                                                                                                                                                                       | There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used                                                                                               |
| <b>Jemperli<br/>(dostarlimab-gxly)</b> | recurrent or metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) recurrent or advanced endometrial cancer                                                                  | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) cannot be used                              |
|                                        | primary advanced or recurrent endometrial cancer                                                                                                                                                              | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) cannot be used                              |
| <b>Libtayo<br/>(cemiplimab-rwlc)</b>   | advanced non-small cell lung cancer (NSCLC)                                                                                                                                                                   | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) and Tecentriq (atezolizumab) cannot be used |
|                                        | metastatic or locally advanced Cutaneous squamous cell carcinoma (CSCC)                                                                                                                                       | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) cannot be used                              |
| <b>Opdivo</b>                          | unresectable or metastatic melanoma (cutaneous) when requested as first-line, single-agent therapy                                                                                                            | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) cannot be used                              |
|                                        | unresectable or metastatic melanoma (cutaneous) when requested as single-agent therapy for second-line or subsequent therapy after disease progression or maximum clinical benefit from BRAF targeted therapy | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) cannot be used                              |
|                                        | metastatic non-small cell lung cancer (NSCLC) when requested as single-agent therapy                                                                                                                          | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) and Tecentriq (atezolizumab) cannot be used |

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|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>(nivolumab)/Opdivo Qvantig (nivolumab and hyaluronidase-nvhy)</b> | classical Hodgkin lymphoma (cHL)                                                                                                                                                                                                                                                                                                               | There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used                                                                  |
|                                                                      | locally advanced or metastatic urothelial carcinoma                                                                                                                                                                                                                                                                                            | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) cannot be used |
|                                                                      | unresectable metastatic colorectal cancer that is defective for mismatch repair/high microsatellite instability (dMMR/MSI-H) when requested as single-agent therapy                                                                                                                                                                            | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) cannot be used |
|                                                                      | metastatic anal carcinoma                                                                                                                                                                                                                                                                                                                      | There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used                                                                  |
|                                                                      | Merkel Cell Carcinoma                                                                                                                                                                                                                                                                                                                          | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) cannot be used |
|                                                                      | Gestational Trophoblastic Neoplasia                                                                                                                                                                                                                                                                                                            | There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used                                                                  |
|                                                                      | advanced or metastatic small bowel adenocarcinoma that is deficient mismatch repair/microsatellite instability- high (dMMR/MSI-H) when requested as single agent therapy                                                                                                                                                                       | There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used                                                                  |
|                                                                      | relapsed/refractory Extranodal NK/T-Cell Lymphoma, nasal type                                                                                                                                                                                                                                                                                  | There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used                                                                  |
|                                                                      | recurrent or metastatic cervical cancer                                                                                                                                                                                                                                                                                                        | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) cannot be used |
| <b>Tevimbra (tislevlizumab-jsgr)</b>                                 | First line treatment of unresectable or metastatic esophageal squamous cell carcinoma (ESCC) in combination with platinum-containing chemo <b>OR</b> first line treatment of unresectable or metastatic HER2-negative gastric or gastroesophageal junction adenocarcinoma in combination with platinum and fluoropyrimidine-based chemotherapy | There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used                                                                  |

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|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Unloxyt<br/>(cosibelimab-<br/>ipdl)</b> | metastatic cutaneous squamous cell carcinoma (mCSCC) or locally advanced cutaneous squamous cell carcinoma (laCSCC)                                                                                                                       | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) cannot be used |
| <b>Yervoy<br/>(ipilimumab)</b>             | unresectable or metastatic melanoma (cutaneous) when requested single-agent, second-line, or subsequent line therapy for metastatic or unresectable disease after disease progress or maximum clinical benefit from BRAF targeted therapy | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) cannot be used |
| <b>Zynyz<br/>(retifanlimab-<br/>dlwr)</b>  | recurrent locally advanced or metastatic Merkel Cell Carcinoma                                                                                                                                                                            | There must be adequate medical justification as to why Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) cannot be used |

#### **IMPORTANT INFORMATION ON ACCELERATED APPROVAL:**

Please refer to the following FDA websites for up-to-date information on ongoing, verified, and withdrawn accelerated approval indications:

**Ongoing Cancer Accelerated Approvals:** <https://www.fda.gov/drugs/resources-information-approved-drugs/ongoing-cancer-accelerated-approvals>

**Verified Clinical Benefit Cancer Accelerated Approvals:** <https://www.fda.gov/drugs/resources-information-approved-drugs/verified-clinical-benefit-cancer-accelerated-approvals>

**Withdrawn Cancer Accelerated Approvals\*:** <https://www.fda.gov/drugs/resources-information-approved-drugs/withdrawn-cancer-accelerated-approvals>

\*Note: Individuals currently receiving treatment for a withdrawn indication should consult with their healthcare provider whether to remain on treatment. Coverage of a treatment with a withdrawn indication will only be considered should the patient be established on therapy prior to the withdrawal date listed on the FDA website

#### **CODES:**

Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. Codes may not be covered under all circumstances. Please read the policy and guidelines statements carefully. Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).  
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**HCPCS:** See drug specific criteria for the associated HCPCS code

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#### **UPDATES:**

| <b>Date</b> | <b>Revision</b>                                |
|-------------|------------------------------------------------|
| 08/03/2026  | Revised                                        |
| 04/13/2026  | Revised                                        |
| 02/12/2026  | Reviewed / P&T Committee Approval              |
| 11/19/2025  | Revised                                        |
| 11/13/2025  | Reviewed / P&T Committee Approval              |
| 11/03/2025  | Revised                                        |
| 10/10/2025  | Revised                                        |
| 09/11/2025  | Revised                                        |
| 08/14/2025  | Reviewed / P&T Committee Approval              |
| 07/01/2025  | Revised                                        |
| 05/19/2025  | Revised                                        |
| 05/08/2025  | Reviewed / P&T Committee Approval              |
| 04/02/2025  | Revised                                        |
| 03/06/2025  | Revised                                        |
| 02/06/2025  | P&T Committee Review & Approval                |
| 02/03/2025  | Revised                                        |
| 01/17/2025  | Revised                                        |
| 12/15/2024  | Revised                                        |
| 11/21/2024  | Reviewed / Approved P&T Committee              |
| 11/14/2024  | Revised                                        |
| 09/27/2024  | Revised                                        |
| 09/20/2024  | Revised                                        |
| 06/20/2024  | Revised                                        |
| 03/21/2024  | Revised                                        |
| 01/04/2024  | Revised                                        |
| 11/01/2023  | Revised                                        |
| 05/19/2023  | Revised                                        |
| 03/20/2023  | Revised                                        |
| 02/09/2023  | P&T Committee Approval                         |
| 01/01/2023  | Revised                                        |
| 09/2022     | Revised                                        |
| 04/2022     | Revised                                        |
| 02/2022     | Revised / P&T Committee Approval               |
| 11/2021     | Revised                                        |
| 10/2021     | Revised                                        |
| 09/2021     | Revised                                        |
| 07/2021     | Revised                                        |
| 05/2021     | Revised                                        |
| 04/2021     | Revised                                        |
| 03/2021     | Revised                                        |
| 02/11/2021  | P&T Committee Approval                         |
| 12/2020     | Created (moved from the Oncology Medical CRPA) |

#### **REFERENCES:**

In addition to the full prescribing information for each individual drug and NCCN Drugs and Biologic Compendium, any references that have been utilized in creating drug specific criteria will be listed below.