Clinical Policy: Durvalumab (Imfinzi)
Reference Number: CP.PHAR.339
Effective Date: 07.01.17
Last Review Date: 05.21
Line of Business: Commercial, HIM, Medicaid

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 adult patients with unresectable, stage III non-small cell lung cancer (NSCLC) whose disease has not progressed following concurrent platinum-based chemotherapy and radiation therapy.
- In combination with etoposide and either carboplatin or cisplatin as first-line treatment of adults patients with extensive-stage small cell lung cancer (ES-SCLC).

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. Non-Small Cell Lung Cancer (must meet all):
      1. Diagnosis of unresectable, stage II-III NSCLC;
      2. Prescribed by or in consultation with an oncologist;
      3. Disease has not progressed following concurrent platinum-based chemotherapy and radiation therapy (RT);
      4. Request meets one of the following (a, b, or c):*
         a. For body weight < 30 kg, dose does not exceed 10 mg/kg every 2 weeks;
         b. For body weight ≥ 30 kg, dose does not exceed 10 mg/kg every 2 weeks or 1,500 mg every 4 weeks;
         c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).
   *Prescribed regimen must be FDA-approved or recommended by NCCN
   Approval duration: 6 months

   B. Extensive-Stage Small Cell Lung Cancer (must meet all):
      1. Diagnosis of ES-SCLC;
      2. Prescribed by or in consultation with an oncologist;
3. Prescribed as first-line treatment with etoposide and either carboplatin or cisplatin, followed by maintenance with Imfinzi as a single agent;
4. Request meets one of the following (a, b, or c):*
   a. For body weight < 30 kg, dose does not exceed 20 mg/kg every 3 weeks in combination with chemotherapy for 4 cycles, then 10 mg/kg every 2 weeks as a single agent;
   b. For body weight ≥ 30 kg, dose does not exceed 1,500 mg every 3 weeks in combination with chemotherapy for 4 cycles, then 1,500 mg every 4 weeks as a single agent;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence).

*Prescribed regimen must be FDA-approved or recommended by NCCN

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): CP.CPA.09 for commercial, HIM.PA.154 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. If request is for a dose increase, request meets one of the following (a, b, or c):*
   a. NSCLC (i or ii):
      i. For body weight < 30 kg, new dose does not exceed 10 mg/kg every 2 weeks;
      ii. For body weight ≥ 30 kg, new dose does not exceed 10 mg/kg every 2 weeks or 1,500 mg every 4 weeks;
   b. ES-SCLC (i or ii):
      i. For body weight < 30 kg, new dose does not exceed 20 mg/kg every 3 weeks in combination with chemotherapy for 4 cycles, then 10 mg/kg every 2 weeks as a single agent;
      ii. For body weight ≥ 30 kg, new dose does not exceed 1,500 mg every 3 weeks in combination with chemotherapy for 4 cycles, and then 1,500 mg every 4 weeks as a single agent;
   c. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence).

*Prescribed regimen must be FDA-approved or recommended by NCCN

Approval duration:
NSCLC: up to a total duration of 12 months
All other indications: 12 months
B. Other diagnoses/indications (must meet 1 or 2):
   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): CP.CPA.09 for commercial, HIM.PA.154 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 – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   ES-SCLC: extensive-stage small cell lung cancer
   NSCLC: non-small cell lung cancer
   RT: radiotherapy
   FDA: Food and Drug Administration

   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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/ Maximum Dose</th>
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<tbody>
<tr>
<td>NSCLC (examples of concurrent platinum-containing/radiotherapy regimens)</td>
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<tr>
<td>cisplatin, etoposide, RT</td>
<td>Varies</td>
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<tr>
<td>carboplatin, pemetrexed, RT</td>
<td>Varies</td>
<td></td>
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<tr>
<td>paclitaxel, carboplatin, RT</td>
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<tr>
<td>ES-SCLC (regimen examples as included in the NCCN SCLC guidelines)</td>
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<tr>
<td>(carboplatin or cisplatin) and etoposide and Imfinzi</td>
<td>Carboplatin AUC 5-6 day 1 and etoposide 80-100 mg/m² days 1, 2, 3 and Imfinzi 1,500 mg day 1 every 21 days x 4 cycles followed by maintenance Imfinzi 1,500 mg day 1 every 28 days</td>
<td>See dosing regimens</td>
</tr>
<tr>
<td></td>
<td>Cisplatin 75-80 mg/m² day 1 and etoposide 80-100 mg/m² days 1, 2, 3 and Imfinzi 1,500 mg day 1 every 21 days x 4 cycles followed by maintenance Imfinzi 1,500 mg day 1 every 28 days</td>
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Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information
On February 22, 2021, AstraZeneca announced the voluntary withdrawal of the indication for Imfinzi for second-line treatment of locally advanced or metastatic bladder cancer. Imfinzi was approved for this indication under the accelerated pathway in 2017, based on study results that showed positive tumor response rates and duration of response. In its announcement, AstraZeneca pointed to results from the DANUBE confirmatory trial, in which Imfinzi failed to meet its key primary endpoint of overall survival.

V. Dosage and Administration

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<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
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| NSCLC      | Weight ≥ 30 kg: 10 mg/kg IV every 2 weeks or 1,500 mg every 4 weeks  
Weight < 30 kg: 10 mg/kg IV every 2 weeks | See regimen; maximum duration of 12 months |
| ES-SCLC    | Weight ≥ 30 kg: 1,500 mg IV in combination with chemotherapy* every 3 weeks (21 days) for 4 cycles, followed by 1,500 mg every 4 weeks as a single agent  
Weight < 30 kg: 20 mg/kg IV in combination with chemotherapy* every 3 weeks (21 days) for 4 cycles, followed by 10 mg/kg every 2 weeks as a single agent | See regimen |

*Administer Imfinzi prior to chemotherapy on the same day. When Imfinzi is administered in combination with chemotherapy, refer to the Prescribing Information for etoposide and carboplatin or cisplatin for dosing information. [See also Appendix B. Therapeutic Alternatives for NCCN regimens as carboplatin, cisplatin, and etoposide are off-label for ES-SCLC.]

VI. Product Availability
Single-dose vials: 120 mg/2.4 mL, 500 mg/10 mL

VII. References
CLINICAL POLICY
Durvalumab


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.

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<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tr>
<td>J9999</td>
<td>Injection, not otherwise classified, antineoplastic drugs</td>
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<tr>
<td>C9492</td>
<td>Injection, durvalumab, 10 mg</td>
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Reviews, Revisions, and Approvals

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<th>Date</th>
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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.

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2Q 2019 annual review: no significant changes; references reviewed and updated.

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No significant changes; revised formatting only.

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2Q 2020 annual review: HIM line of business added; UC stage III added to encompass NCCN recommended use for locally advanced disease; NCCN recommended use for SCLC added; references reviewed and updated.

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FDA new indication added for ES-SCLC; references reviewed and updated.

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Added Commercial line of business

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2Q 2021 annual review: removed criteria for bladder cancer as the FDA labeled indication was withdrawn by the manufacturer based on confirmatory trial results; added coverage for stage II NSCLC per NCCN 2A recommendation; revised dosing for all indications per updated FDA label; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.

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<th>Date</th>
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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.