Clinical Policy: Enfortumab Vedotin-ejfv (Padcev)
Reference Number: CP.PHAR.455
Effective Date: 03.01.20
Last Review Date: 02.20
Line of Business: HIM, Medicaid

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

Description
Enfortumab vedotin-ejfv (Padcev™) is a Nectin-4-directed antibody and microtubule inhibitor conjugate.

FDA Approved Indication(s)
Padcev is indicated for the treatment of adult patients with locally advanced or metastatic urothelial cancer who have previously received a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor, and a platinum-containing chemotherapy in the neoadjuvant/adjuvant, locally advanced or metastatic setting.

This indication is approved under accelerated approval based on tumor response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

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 Padcev is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Urothelial Cancer (must meet all):
      1. Diagnosis of locally advanced or metastatic (stage IV) urothelial cancer;
      2. Prescribed by or in consultation with an oncologist;
      3. Age ≥ 18 years;
      4. Failure of both of the following in the neoadjuvant/adjuvant, locally advanced or metastatic setting (a and b):
         a. A programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor (see Appendix B);
         b. A platinum-containing chemotherapy (see Appendix B);
      5. Request meets one of the following (a or b):*
         a. Dose does not exceed 125 mg on Days 1, 8, and 15 of a 28-day cycle;
         b. 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. 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. Urothelial Cancer (must meet all):
      1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Padcev 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 or b):
         a. New dose does not exceed 125 mg on Days 1, 8 and 15 of a 28-day cycle;
         b. 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: 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): 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
   PD-1: programmed death receptor-1
   PD-L1: programmed death-ligand

   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.
### Examples of platinum-containing regimens

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>DDMVAC (dose-dense methotrexate, vinblastine, doxorubicin, and cisplatin)</td>
<td>Varies</td>
<td>Varies</td>
</tr>
<tr>
<td>gemcitabine with either cisplatin or carboplatin</td>
<td>Varies</td>
<td>Varies</td>
</tr>
</tbody>
</table>

### Examples of PD-1 and PD-L1 inhibitors

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keytruda® (pembrolizumab)</td>
<td>200 mg IV every 3 weeks</td>
<td>Varies</td>
</tr>
<tr>
<td>Tecentriq® (atezolizumab)</td>
<td>Varies</td>
<td>Varies</td>
</tr>
<tr>
<td>Opdivo® (nivolumab)</td>
<td>Varies</td>
<td>Varies</td>
</tr>
<tr>
<td>Imfinzi® (durvalumab)</td>
<td>10 mg/kg IV infusion every 2 weeks</td>
<td>Varies</td>
</tr>
<tr>
<td>Bavencio® (avelumab)</td>
<td>800 mg IV infusion once every 2 weeks</td>
<td>Varies</td>
</tr>
</tbody>
</table>

*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.*

### Appendix C: Contraindications/Boxed Warnings

None reported

### V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urothelial cancer</td>
<td>1.25 mg/kg (up to a maximum dose of 125 mg) given as an intravenous infusion over 30 minutes on Days 1, 8 and 15 of a 28-day cycle until disease progression or unacceptable toxicity</td>
<td>125 mg for patients ≥ 100 kg) on Days 1, 8 and 15 of a 28-day cycle</td>
</tr>
</tbody>
</table>

### VI. Product Availability

Single-dose vial for injection: 20 mg, 30 mg

### VII. References


### 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 information for coding guidance.
date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>TBD</td>
<td>Injection, enfortumab vedotin-ejfv, 10 mg</td>
</tr>
<tr>
<td>J9999</td>
<td>Injection, not otherwise classified, antineoplastic drugs</td>
</tr>
</tbody>
</table>

### Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
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<tbody>
<tr>
<td>01.14.20</td>
<td>02.20</td>
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</table>

**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.

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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.

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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.

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