ONCOLOGY MEDICATION CLINICAL COVERAGE

Policy Number: CS2019D0030P Effective Date: October 1, 2019

Table of Contents Page

APPLICATION .......................................................... 1
COVERAGE RATIONALE ........................................... 1
BENEFIT CONSIDERATIONS ..................................... 3
REFERENCES ......................................................... 3
POLICY HISTORY/REVISION INFORMATION ............... 4
INSTRUCTIONS FOR USE ......................................... 5

Related Community Plan Policy
- Denosumab (Prolia® & Xgeva®)
- Erythropoiesis-Stimulating Agents
- Lemtrada (Alemtuzumab)
- Rituximab (Rituxan® & Truxima®)
- Therapeutic Radiopharmaceuticals
- White Blood Cell Colony Stimulating Factors

Commercial Policy
- Oncology Medication Clinical Coverage

Related Guidelines
- Transplant Review Guidelines: Hematopoietic Stem Cell Transplantation

APPLICATION

This policy does not apply to the states of Kansas and Louisiana.
- For the state of Louisiana, refer to the Medical Benefit Drug Policy titled Oncology Medication Clinical Coverage (for Louisiana Only).

The preferred product criteria for Mvasi and Kanjinti does not apply to the states of Arizona, Washington, and Wisconsin.

COVERAGE RATIONALE

Description
This policy provides parameters for coverage of injectable oncology medications (J9000–J9999) [including, but not limited to octreotide acetate (J2353 and J2354), leuprolide acetate (J1950), leucovorin (J0640) and levoleucovorin (J0641)] covered under the medical benefit based upon the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium® (NCCN Compendium®). The Compendium lists the appropriate drugs and biologics for specific cancers using U.S. Food and Drug Administration (FDA)-approved disease indications and specific NCCN panel recommendations. Each recommendation is supported by a level of evidence category. Coverage of White Blood Cell Colony Stimulating Factors is addressed in a separate policy. This policy does not provide coverage criteria for Chimeric Antigen Receptor (CAR)–T Cell products. Coverage determinations are based on the member's benefits and the OptumHealth Transplant Solutions criteria for covered transplants in the Clinical Guideline titled Transplant Review Guidelines: Hematopoietic Stem Cell Transplantation.

Coverage Rationale
The Oncology Products table below lists the UnitedHealthcare preferred oncology products and respective non-preferred products. Coverage will be provided for the UnitedHealthcare preferred oncology product contingent on the coverage criteria in the Diagnosis-Specific Criteria section.

Coverage for any respective non-preferred oncology product will be provided contingent on the criteria in the Medical Necessity Criteria and the Diagnosis-Specific Criteria sections.
Medical Necessity Criteria

Treatment with the respective non-preferred product specified in the Oncology Products table below is medically necessary for oncology indications when BOTH of the following are met:

- History of intolerance or contraindication to the UnitedHealthcare preferred oncology product; and
- Physician attests that, in their clinical opinion, the same intolerance, contraindication, or adverse event would not be expected to occur with the respective non-preferred product

Oncology Products

Below are UnitedHealthcare preferred oncology products with therapeutically equivalent and/or biosimilar* non-preferred products as determined by the UnitedHealthcare P&T Committee:

<table>
<thead>
<tr>
<th>Preferred Oncology Product</th>
<th>Non-Preferred Oncology Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mvasi (bevacizumab-awwb)</td>
<td>Avastin (bevacizumab)</td>
</tr>
<tr>
<td></td>
<td>Zirabev (bevacizumab-bvzr)</td>
</tr>
<tr>
<td>Kanjinti (trastuzumab-anss)</td>
<td>Herceptin (trastuzumab)</td>
</tr>
<tr>
<td></td>
<td>Herceptin Hylecta (trastuzumab and hyaluronidase-oysk)</td>
</tr>
<tr>
<td></td>
<td>Herzuma (trastuzumab-pkrb)</td>
</tr>
<tr>
<td></td>
<td>Ogivri (trastuzumab-dkst)</td>
</tr>
<tr>
<td></td>
<td>Ontruzant (trastuzumab-ddtb)</td>
</tr>
<tr>
<td></td>
<td>Trazimera (trastuzumab-qyyp)</td>
</tr>
<tr>
<td>Leucovorin</td>
<td>Levoleucovorin</td>
</tr>
</tbody>
</table>

*Biosimilar means that the biological product is FDA-approved based on data demonstrating that it is highly similar to an already FDA-approved biological product, known as a reference product, and that there are no clinically meaningful differences between the biosimilar product and the reference product.

Diagnosis-Specific Criteria

Injectable Oncology Medications

UnitedHealthcare recognizes indications and uses of injectable oncology medications listed in the NCCN Drugs and Biologics Compendium with Categories of Evidence and Consensus of 1, 2A, and 2B as proved and medically necessary, and Categories of Evidence and Consensus of 3 as unproved and not medically necessary. (However, see Benefit Considerations.)

UnitedHealthcare will cover all chemotherapy agents for individuals under the age of 19 years for oncology indications. The majority of pediatric patients receive treatments on national pediatric protocols that are quite similar in concept to the NCCN patient care guidelines.

Refer to Medical Necessity Criteria for the UnitedHealthcare preferred oncology products that have therapeutically equivalent and/or biosimilar products available.

Additional Information

The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) are comprehensive guidelines documenting management decisions and interventions and interventions that apply to malignancies which apply to more than 97% of cancers affecting U.S. patients.

NCCN Categories of Evidence and Consensus

Category 1

The recommendation is based on high-level evidence (i.e., high-powered randomized clinical trials or meta-analyses), and the panel has reached uniform consensus that the recommendation is indicated. In this context, uniform means near unanimous positive support with some possible neutral positions.

Category 2A

The recommendation is based on lower level evidence, but despite the absence of higher level studies, there is uniform consensus that the recommendation is appropriate. Lower level evidence is interpreted broadly, and runs the gamut from phase II to large cohort studies to case series to individual practitioner experience. Importantly, in many instances, the retrospective studies are derived from clinical experience of treating large numbers of patients at a member institution, so panel members have first-hand knowledge of the data. Inevitably, some recommendations must address clinical situations for which limited or no data exist. In these instances the congruence of experience-based opinions provides an informed if not confirmed direction for optimizing patient care. These recommendations carry the implicit recognition that they may be superseded as higher level evidence becomes available or as outcomes-based information becomes more prevalent.
Category 2B
The recommendation is based on lower level evidence, and there is nonuniform consensus that the recommendation should be made. In these instances, because the evidence is not conclusive, institutions take different approaches to the management of a particular clinical scenario. This nonuniform consensus does not represent a major disagreement, rather it recognizes that given imperfect information, institutions may adopt different approaches. A Category 2B designation should signal to the user that more than one approach can be inferred from the existing data.

Category 3
The recommendation has engendered a major disagreement among the panel members. Several circumstances can cause major disagreements. For example, if substantial data exist about two interventions but they have never been directly compared in a randomized trial, adherents to one set of data may not accept the interpretation of the other side's results. Another situation resulting in a Category 3 designation is when experts disagree about how trial data can be generalized. A Category 3 designation alerts users to a major interpretation issue in the data and directs them to the manuscript for an explanation of the controversy.

BENEFIT CONSIDERATIONS

Chimeric Antigen Receptor (CAR)-T Cell Therapy may be eligible for coverage as an autologous stem cell therapy under a member’s Transplantation Services benefit. Coverage determinations are based on the OptumHealth Transplant Solutions criteria for covered transplants in the Clinical Guideline titled Transplant Review Guidelines: Hematopoietic Stem Cell Transplantation.

REFERENCES

1. NCCN Drugs and Biologics Compendium (NCCN Compendium). http://www.nccn.org/professionals/drug_compendium/content/contents.asp.
**Notice of Revision**: The following summary of changes has been modified. Revisions to the previous policy update announcement are outlined in red below. Please take note of the additional updates implemented on **Oct. 1, 2019**.

**Template Update**
- Reorganized policy template:
  - Simplified and relocated *Application* section; previously titled *State Exceptions*

**Related Policies**
- Added reference link to the Medical Policy titled *Therapeutic Radiopharmaceuticals*

**Application**
- Added language to indicate:
  - This policy does not apply to the state of Louisiana; refer to the Medical Benefit Drug Policy titled *Oncology Medication Clinical Coverage (for Louisiana Only)*
  - The preferred product criteria for Mvasi and Kanjinti does not apply to the states of Arizona, Washington, and Wisconsin

**Coverage Rationale**
- Removed language pertaining to "select ancillary and supportive care medications for oncology conditions"
- Added language to indicate:
  - Coverage of *White Blood Cell Colony Stimulating Factors* is addressed in a separate policy
  - The *Oncology Products* table lists the UnitedHealthcare preferred oncology products and respective non-preferred products; coverage will be provided for the UnitedHealthcare preferred oncology product contingent on the coverage criteria in the *Diagnosis-Specific Criteria* section of the policy
  - Coverage for any respective non-preferred oncology product will be provided contingent on the criteria in the *Medical Necessity Criteria* and the *Diagnosis-Specific Criteria* sections of the policy; members new to therapy will be required to utilize the UnitedHealthcare preferred oncology product unless they meet the [following] criteria:
    - Treatment with the respective non-preferred product specified in the *Oncology Products* table is medically necessary for oncology indications when both of the following are met:
      - History of intolerance or contraindication to the UnitedHealthcare preferred oncology product; and
      - Physician attests that, in their clinical opinion, the same intolerance, contraindication, or adverse event would not be expected to occur with the respective non-preferred product
  - The *Oncology Products* table lists the UnitedHealthcare preferred oncology products with therapeutically equivalent and/or biosimilar non-preferred products as determined by the UnitedHealthcare Pharmacy and Therapeutics (P&T) Committee; biosimilar means that the biological product is FDA-approved based on data demonstrating that it is highly similar to an already FDA-approved biological product, known as a reference product, and that there are no clinically meaningful differences between the biosimilar product and the reference product

**Diagnosis-Specific Criteria**
- Refer to the *Medical Necessity Criteria* section of the policy for the UnitedHealthcare preferred oncology products that have therapeutically equivalent and/or biosimilar products available

**Additional Information**
- Modified language to indicate the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) are comprehensive guidelines documenting management decisions and interventions and interventions that apply to malignancies which apply to more than 97% of cancers affecting U.S. patients
INSTRUCTIONS FOR USE

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage.

UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.