Oncology Medication Clinical Coverage

Policy Number: 2024D0030AK
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Description

This policy provides parameters for coverage of injectable oncology medications (including, but not limited to octreotide acetate, leuprolide acetate, leucovorin, and levoleucovorin), including therapeutic radiopharmaceuticals, 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 US 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 and Erythropoiesis-Stimulating Agents are addressed in separate policies. 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; refer to the Clinical Guideline titled Chimeric Antigen Receptor T-cell Therapy.

Coverage Rationale

Medical Necessity Plans

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 Preferred Product Criteria and the Diagnosis-Specific Criteria sections. Members new to therapy will be required to utilize the UnitedHealthcare preferred oncology product unless they meet the criteria in this section.

Preferred Product Criteria *(For Medicare reviews, refer to the CMS section.***)*

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:

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- History of intolerance or contraindication to one of the UnitedHealthcare's preferred oncology products; 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:

Preferred Oncology Product	Non-Preferred Oncology Product	Indications
Mvasi (bevacizumab-awwb)	Avastin (bevacizumab) Zirabev (bevacizumab-bvzr) Alymsys (bevacizumab-maly) Vegzelma (bevacizumab-adcd)	All oncology indications
Kanjinti (trastuzumab-anns) Trazimera (trastuzumab-qyyp) Ogivri (trastuzumab-dkst)	Herceptin (trastuzumab) Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) Herzuma (trastuzumab-pkrb) Ontruzant (trastuzumab-dttb)	All oncology indications
Kanjinti (trastuzumab-anns) + Perjeta (pertuzumab) Phesgo (pertuzumab, trastuzumab, hyaluronidase-zzxf) Trazimera (trastuzumab-qyyp) + Perjeta (pertuzumab) Ogivri (trastuzumab-dkst) + Perjeta (pertuzumab)	Herceptin (trastuzumab) + Perjeta (pertuzumab) Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) + Perjeta (pertuzumab) Herzuma (trastuzumab-pkrb) + Perjeta (pertuzumab) Ontruzant (trastuzumab-dttb) + Perjeta (pertuzumab)	All oncology indications
Ruxience (rituximab-pvvr) Truxima (rituximab-abbs)	Rituxan (rituximab) Rituxan Hycela (rituximab/hyaluronidase human, recombinant) Riabni (rituximab-arrx)	All oncology indications
Gemcitabine	Infugem (gemcitabine in sodium chloride injection)	All oncology indications
Leucovorin	Levoleucovorin	All oncology indications
Eligard (leuprolide acetate), Lupron Depot 7.5 mg (leuprolide acetate for depot suspension - J9217, J1954), Zoladex (Goserelin acetate)	Lupron Depot 3.75 mg (leuprolide acetate for depot suspension - J1950)	All oncology indications
Somatuline Depot (Lanreotide - J1930)	Lanreotide (J1932)	All oncology indications
Keytruda (pembrolizumab) Libtayo (cemiplimab-rwlc) Tecentriq (atezolizumab)	Opdivo (nivolumab) + Yervoy (ipilimumab)	Non-Small Cell Lung Cancer: Advanced or Metastatic, Monotherapy, PD-L1 expression positive ≥50%
Loqtorzi (toripalimab-tpzi)	Keytruda (pembrolizumab) Opdivo (nivolumab)	Head and Neck Cancers: Recurrent, Unresectable, Oligometastatic, or Metastatic Disease, Nasopharyngeal
Alimta, Pemetrexed (J9294, J9296, J9297, J9305, J9314, J9322)	Pemfexy (pemetrexed - J9304)	All oncology indications

Any U.S. Food and Drug Administration approved product that may belong to UnitedHealthcare Preferred or Non-preferred Oncology Product categories but not listed by name in this policy will be considered non-preferred until reviewed by UnitedHealthcare P&T committee.

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Diagnosis-Specific Criteria

Injectable Oncology Medications

UnitedHealthcare recognizes indications and uses of injectable oncology medications, including therapeutic radiopharmaceuticals, listed in the NCCN Drugs and Biologics Compendium with Categories of Evidence and Consensus of 1, 2A, and 2B as proven and medically necessary, and Categories of Evidence and Consensus of 3 as unproven and not medically necessary.

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 Preferred Product Criteria for the UnitedHealthcare preferred oncology products and indications.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
A9513	Lutetium lu 177, dotatate, therapeutic, 1 millicurie
A9590	Iodine i-131, iobenguane, 1 millicurie
A9606	Radium Ra-223 dichloride, therapeutic, per microcurie
A9607	Lutetium Lu 177 vipivotide tetraxetan, therapeutic, 1 millicurie
A9699	Radiopharmaceutical, therapeutic, not otherwise classified
J0640	Injection, leucovorin calcium, 50 mg
J0641	Injection, levoleucovorin, not otherwise specified, 0.5 mg
J0642	Injection, levoleucovorin (khapzory), 0.5 mg
J1930	Lanreotide injection
J1932	Inj, lanreotide, (cipla), 1mg
J1950	Injection, leuprolide acetate (for depot suspension), 3.75 mg
J1954	Injection, leuprolide acetate for depot suspension (cipla), 7.5 mg
J3263	Inejction, toripalimab-tpzi, 1 mg
J9022	Injection, atezolizumab, 10 mg
J9035	Injection, bevacizumab, 10 mg
J9119	Injection, cemiplimab-rwlc, 1 mg
J9198	Injection, gemcitabine hydrochloride, (infugem), 100 mg
J9199	Injection, gemcitabine hydrochloride (infugem), 200 mg
J9201	Injection, gemcitabine hydrochloride, 200 mg
J9202	Goserelin acetate implant
J9217	Injection, leuprolide acetate (for depot suspension), 7.5 mg
J9228	Injection, ipilimumab, 1 mg
J9271	Injection, pembrolizumab, 1 mg
J9299	Injection, nivolumab, 1 mg
J9294	Injection, pemetrexed (Hospira), not therapeutically equivalent to J9305, 10 mg
J9296	Injection, pemetrexed (Accord), not therapeutically equivalent to J9305, 10 mg

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HCPCS Code	Description
J9297	Injection, pemetrexed (Sandoz) 10mg
J9304	Injection, pemetrexed, 10 mg
J9305	Injection, pemetrexed nos 10mg
J9310	Injection, rituximab, 100 mg
J9311	Injection, rituximab, hyaluronidase, 10 mg
J9312	Injection, rituximab, 10 mg
J9314	Injection, pemetrexed (Teva), not therapeutically equivalent to J9305, 10 mg
J9316	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, 10 mg
J9322	Injection, pemetrexed (BluePoint), 10 mg
J9355	Injection, trastuzumab, 10 mg
J9356	Injection, trastuzumab, 10 mg and Hyaluronidase-oysk
Q5107	Injection, bevacizumab-awwb, biosimilar (mvasi), 10 mg
Q5112	Injection, trastuzumab-dttb, biosimilar (ontruzant), 10 mg
Q5113	Injection, trastuzumab-pkrb, biosimilar (herzuma), 10 mg
Q5114	Injection, trastuzumab-dkst, biosimilar (ogivri), 10 mg
Q5115	Injection, rituximab-abbs, biosimilar (truxima), 10 mg
Q5116	Injection, trastuzumab-qyyp, biosimilar (trazimera), 10 mg
Q5117	Injection, trastuzumab-anns, biosimilar (kanjinti), 10 mg
Q5118	Injection, bevacizumab-bvzr, biosimilar (zirabev), 10 mg
Q5119	Injection, rituximab-pvvr, biosimilar (ruxience), 10 mg
Q5123	Injection, rituximab-arrx, biosimilar (riabni), 10mg
Q5126	Injection, bevacizumab-maly, biosimilar, (alymsys), 10 mg
Q5129	Injection, bevacizumab-adcd, biosimilar, (vegzelma), 10 mg

Background

The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) are comprehensive guidelines documenting management decisions and interventions that apply to 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,

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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 exists 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.

Therapeutic radiopharmaceuticals [e.g., Azedra® (iobenguane I 131), Lutathera® (lutetium Lu 177 dotatate), Xofigo® (radium-223)] used to treat cancer are medications that contain radioactive material. The radioactive agent selectively accumulates within the tumor releasing radiation which then kills cancer cells.

Benefit Considerations

If the coverage review using the NCCN Compendium determines that the drug is unproven, then further review is indicated. Some Certificates of Coverage allow for coverage of experimental/investigational/unproven treatments for life-threatening illnesses when certain conditions are met. The member specific benefit plan document must be consulted to make coverage decisions for this service. Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances. Some states also mandate usage of other Compendium references. Where such mandates apply, they supersede language in the member specific benefit plan document or in this policy.

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; refer to the Clinical Guideline titled Chimeric Antigen Receptor T-cell Therapy.

Benefit coverage for an otherwise unproven service for the treatment of serious rare diseases may occur when certain conditions are met. Refer to the Policy and Procedure addressing the treatment of serious rare diseases.

Centers for Medicare and Medicaid Services (CMS)

Medicare does not have a National Coverage Determination (NCD) that addresses preferred or non-preferred medications used to treat cancer. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

Medicare does have an NCD that addresses chemotherapy. Refer to the NCD for Anti-Cancer Chemotherapy for Colorectal Cancer (110.17). LCDs/LCAs exist, refer to the following LCDs/LCAs at: https://www.cms.gov/medicare-coverage-database/new-search/search.aspx:

- Billing and Coding: Additional Claim Documentation Requirements for Not Otherwise Classified (NOC) Drugs and Biological Products with Specific FDA Label Indications
- Billing and Coding: Xofigo Billing Instructions
- Drugs and Biologicals, Coverage of, for Label and Off-Label Uses
- Luteinizing Hormone-Releasing Hormone (LHRH) Analogs
- Rituximab
- Trastuzumab – Trastuzumab Biologics

Medicare may cover outpatient (Part B) drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. Refer to the Medicare Benefit Policy Manual, Chapter 15, §50 - Drugs and Biologicals. (Accessed June 10, 2024)

***Preferred therapy criteria for Medicare Advantage members, refer to Medicare-Part-B-Step-Therapy-Programs.

References

1. The NCCN Drugs and Biologics Compendium (NCCN Compendium®). https://www.nccn.org/compendia-templates/compendia/drugs-and-biologics-compendia.

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2. The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). http://www.nccn.org/professionals/physician_gls/f_guidelines.asp.
3. Pazdur R. Endpoints for assessing drug activity in clinical trials. Oncologist. 2008;13 Suppl 2:19-21.
4. Therasse P, Arbuck SG, Eisenhauer EA, et al. New guidelines to evaluate the response to treatment in solid tumors. European Organization for Research and Treatment of Cancer, National Cancer Institute of the United States, National Cancer Institute of Canada. J Natl Cancer Inst. 2000 Feb 2;92(3):205-16.
5. Center for Drug Evaluation and Research. Biosimilars. Retrieved from https://www.fda.gov/drugs/therapeutic-biologics-applications-bla/biosimilars.

Policy History/Revision Information

Date	Summary of Changes
09/01/2024	**Coverage Rationale** ***Oncology Products*** • Added language to indicate any U.S. Food and Drug Administration approved product that may belong to UnitedHealthcare preferred or non-preferred oncology product categories but not listed by name in this policy will be considered non-preferred until reviewed by UnitedHealthcare P&T committee • Removed notation defining "biosimilar" • Updated list of applicable oncology products: ○ Modified format to include the indications that correspond with each preferred product and their non-preferred equivalents ○ Added: Non-Small Cell Lung Cancer: Advanced or Metastatic, Monotherapy, PD-L1 expression positive ≥ 50% ▪ Preferred: – Keytruda (pembrolizumab) – Libtayo (cemiplimab-rwlc) – Tecentriq (atezolizumab) ▪ Non-Preferred: Opdivo (nivolumab) + Yervoy (ipilimumab) Head and Neck Cancers: Recurrent, Unresectable, Oligometastatic, or Metastatic Disease, Nasopharyngeal ▪ Preferred: Loqtorzi (toripalimab-tpzi) ▪ Non-Preferred: – Keytruda (pembrolizumab) – Opdivo (nivolumab) ○ Updated list of HCPCS codes for preferred Pemetrexed; added J9322 **Applicable Codes** • Added HCPCS codes J3263, J9022, J9119, J9228, J9271, J9299, and J9322 **Supporting Information** • Archived previous policy version 2024D0030AJ

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. 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.

This Medical Benefit Drug Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. 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.

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