Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: 02/01/2023**
Policy Number: PA.CP.PHAR.333	**Effective Date: 01/01/2018** **Revision Date: 01/2023**
Policy Name: Avelumab (Bavencio)	

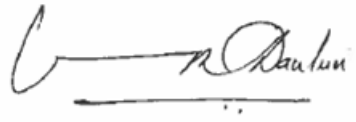
Type of Submission – Check all that apply:

- ☐ **New Policy**
- ✓ **Revised Policy***
- ☐ **Annual Review - No Revisions**
- ☐ **Statewide PDL -** *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

1Q 2023 annual review: no significant changes; per NCCN added recurrent MCC as a covered indication, for gestational trophoblastic neoplasia added requirement for either high-risk disease or recurrent or progressive disease after a platinum-based regimen, and for RCC added the requirement for clear cell histology; references reviewed and updated.

Name of Authorized Individual (Please type or print): **Venkateswara R. Davuluri, MD**	**Signature of Authorized Individual:** 

Clinical Policy: Avelumab (Bavencio)

Reference Number: PA.CP. PHAR.333
Effective Date: 01/2018
Last Review Date: 01/2023 Revision Log

Description
Avelumab (Bavencio®) is a programmed death ligand-1 blocking antibody.

FDA approved indication
Bavencio is indicated for:

- Adults and pediatric patients 12 years and older with metastatic Merkel cell carcinoma (MCC).*
- Maintenance treatment of patients with locally advanced or metastatic urothelial carcinoma (UC) that has not progressed with first-line platinum-containing chemotherapy.
- Patients with locally advanced or metastatic UC who:
  - Have disease progression during or following platinum-containing chemotherapy.
  - Have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.
- First-line treatment, in combination with axitinib, of patients with advanced renal cell carcinoma (RCC).

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

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of PA Health & Wellness® that Bavencio is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Merkel Cell Carcinoma (must meet all)**:**

1. Diagnosis of metastatic or recurrent MCC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 12 years;
4. Request meets one of the following (a or b):
   a. Dose does not exceed 800 mg (4 vials) every two weeks.
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence).*

Approval duration: 6 months

B. Urothelial Carcinoma (must meet all)**:**

1. Diagnosis of recurrent, locally advanced or metastatic UC;

2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Indicated for one of the following (a, b, or c):
   a. Maintenance treatment where disease has not progressed with first-line platinum-containing chemotherapy;
   b. Treatment where disease has progressed during or following platinum-containing chemotherapy;
   c. Treatment where disease has progressed within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy;
5. Prescribed as a single agent;
6. Request meets one of the following (a or b):
   a. Dose does not exceed 800 mg every two weeks;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence).*

Approval duration: 6 months

C. Renal Cell Carcinoma (must meet all)**:**

1. Diagnosis of advanced RCC (e.g., relapse or stage IV disease) with clear cell histology;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed as first-line therapy in combination with Inlyta®;
   **Prior authorization is required for Inlyta*
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 800 mg every two weeks;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence).*

Approval duration: 6 months

D. Other NCCN Recommended Uses (off-label) (must meet all)**:**

1. Diagnosis of one of the following (a or b):
   a. Gestational trophoblastic neoplasia;
   b. Endometrial carcinoma;
2. Prescribed or in consultation with an oncologist;
3. Age ≥ 12 years;
4. For gestational trophoblastic neoplasia: Prescribed as a single agent following failure of ≥ 2 systemic chemotherapeutic agents (see *Appendix B*) and member has one of the following (a or b):
   a. High-risk disease;
   b. Recurrent or progressive intermediate trophoblastic tumor (placental site trophoblastic tumor or epithelioid trophoblastic tumor) following treatment with a platinum-based regimen;
5. For endometrial carcinoma, both of the following (a and b):
   a. Prescribed as a single agent second-line treatment or subsequent therapy (see *Appendix B*);

b. Disease is recurrent or metastatic for microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) tumors;

6. Request meets one of the following (a or b):
   a. Dose does not exceed 800 mg every two weeks;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence).*

Approval duration: 6 months

E. Other diagnoses/indications:

1. Refer to PA.CP.PMN.53

II. Continued Therapy

A. All Indications Specified in Section I (must meet all)**:**

1. Currently receiving medication via PA Health & Wellness benefit or member has previously met initial approval criteria; or the Continuity of Care policy (PA.LTSS.PHAR.01) applies;
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 800 mg (4 vials) every two weeks;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence).*

Approval duration: 12 months

B. Other diagnoses/indications (1 or 2)**:**

1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy; or the Continuity of Care policy (PA.LTSS.PHAR.01) applies.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to PA.CP.PMN.53

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 policy – PA.CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

dMMR: deficient mismatch repair
FDA: Food and Drug Administration
MCC: Merkel cell carcinoma
MSI-H: microsatellite instability-high
NCCN: National Comprehensive Cancer Network
RCC: renal cell carcinoma
UC: urothelial carcinoma

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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Gestational Trophoblastic Neoplasia		
Examples of systemic chemotherapeutic agents: bleomycin, carboplatin, cyclophosphamide, dactinomycin, etoposide, gemcitabine, ifosfamide, mesna, methotrexate, paclitaxel, vincristine.	Varies	Varies
Endometrial carcinoma		
Examples of systemic chemotherapeutic agents: carboplatin/paclitaxel, cisplatin/doxorubicin, carboplatin/paclitaxel/bevacizumab, doxorubicin, topotecan, temsirolimus, ifosfamide	Varies	Varies

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

Indication	Dosing Regimen	Maximum Dose
MCC, UC	800 mg IV infusion every 2 weeks until disease progression or unacceptable toxicity	800 mg every 2 weeks
RCC	800 mg IV infusion every 2 weeks in combination with axitinib	800 mg every 2 weeks

VI. Product Availability

Single-dose vials: 200 mg/10 mL (20 mg/mL)

VII. References

1. Bavencio Prescribing Information. Rockland, MA: EMD Serono, Inc.; July 2022. Available at: https://www.bavencio.com/. Accessed November 22, 2022.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed November 22, 2022.
3. National Comprehensive Cancer Network. Merkel Cell Carcinoma Version 2.2022. Available at www.nccn.org. Accessed November 22, 2022.
4. National Comprehensive Cancer Network. Bladder Cancer Version 2.2022. Available at: www.nccn.org. Accessed November 22, 2022.
5. National Comprehensive Cancer Network. Kidney Cancer Version 3.202. Available at: www.nccn.org. Accessed November 22, 2022.
6. National Comprehensive Cancer Network. Gestational Trophoblastic Neoplasia Version 1.2022. Available at www.nccn.org. Accessed November 22, 2022.
7. National Comprehensive Cancer Network. Uterine Neoplasms Version 1.2022. Available at www.nccn.org. Accessed November 22, 2022.

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.

HCPCS Codes	Description
J9023	Injection, avelumab, 10 mg

Reviews, Revisions, and Approvals	Date	Approval Date
Specialist added to MCC and UC. Age added to MCC. Dose added to UC; "Locally advanced or metastatic" removed given inclusion of criteria requiring progression following platinum-based chemotherapy. NCCN bladder cancer use delineating "as a single agent" removed. References reviewed and updated.	02/2018	
1Q 2019 annual review: age added to UC; reference to bladder cancer as off-label use is removed from the UC criteria set as it and other cancers are included under UC histology; references reviewed and updated.	01/2019	
1Q 2020 annual review: age added to UC; criteria added for new FDA-approved indication for RCC; max dose clarified to 800 mg every 2 weeks; references reviewed and updated.	01/2020	
1Q 2021 annual review: for UC, recurrent disease added per NCCN, and platinum-based chemotherapy history added per label and NCCN; gestational trophoblastic neoplasia off-label use added per NCCN; references reviewed and updated.	01/2021	
1Q 2022 annual review: added criterion that Bavencio be used as single-agent therapy for urothelial carcinoma per NCCN; added endometrial carcinoma indication per NCCN; references reviewed and updated.	01/2022	
1Q 2023 annual review: no significant changes; per NCCN added recurrent MCC as a covered indication, for gestational trophoblastic neoplasia added requirement for either high-risk disease or recurrent or progressive disease after a platinum-based regimen, and for RCC added the requirement for clear cell histology; references reviewed and updated.	01/2023	