Clinical Policy: Avelumab (Bavencio)

Reference Number: PA.CP. PHAR.333
Effective Date: 01/2018
Last Review Date: 01/2026

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).

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 locally advanced, metastatic, recurrent, regional or locally advanced disease 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: 12 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 or other 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: 12 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: 12 months

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

1. Diagnosis of one of the following (a-f):
   a. Gestational trophoblastic neoplasia;
   b. Endometrial carcinoma;
   c. Salivary gland tumor;
   d. Thymic carcinoma;
   e. Extranodal NK/T-cell lymphomas;
   f. Other NCCN recommendations listed as category 1, 2A, or 2B;
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);
5. For endometrial carcinoma, prescribed as second-line or subsequent treatment and in one of the following ways (a and b; see *Appendix B*):
   a. As a single agent for recurrent or metastatic for microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) tumors;

b. In combination with Inlyta for recurrent or metastatic disease that is mismatch repair proficient (pMMR);

6. For salivary gland tumors, prescribed in combination with Inlyta for recurrent adenoid cystic carcinoma with either of the following (a or b):
   a. Distant metastases in patients with a performance status of 0-3;
   b. Unresectable locoregional recurrence or second primary with prior radiation therapy;
   **Prior authorization may be required for Inlyta*
7. For thymic carcinoma, prescribed in combination with Inlyta* and meeting **one** of the following (a-d):
   a. Postoperative systemic therapy after R1 or R2 resection when the member cannot tolerate first-line combination regimens;
   b. First-line systemic therapy for recurrent, advanced, or metastatic disease when the member cannot tolerate first-line combination regimens, and one of the following (i or ii):
      i. After surgery for solitary metastasis or ipsilateral pleural metastasis;
      ii. Medically inoperable/unresectable solitary metastasis or ipsilateral pleural metastasis;
   c. Subsequent systemic therapy for unresectable locally advanced disease, solitary metastasis or ipsilateral pleural metastasis, or extrathoracic metastatic disease;
   d. Other NCCN recommendations listed as category 1, 2A, or 2B;
   **Prior authorization may be required for Inlyta*
8. For extranodal NK-T-cell lymphomas, prescribed for relapsed/refractory disease following additional therapy with an alternative combination chemotherapy regimen (see *Appendix B*) not previously used, if a clinical trial is unavailable;
9. 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: 12 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.PHARM.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.PHARM.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
pMMR: mismatch repair proficient
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
Thymic carcinoma		
Examples of systemic chemotherapeutic agents: carboplatin/paclitaxel, carboplatin/paclitaxel/ramucirumab, cyclophosphamide/doxorubicin/cisplatin/ prednisone, doxorubicin/cisplatin/	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
vincristine/cyclophosphamide, cisplatin/ etoposide, etoposide/ifosfamide/cisplatin		
Extranodal NK/T-cell lymphomas		
Examples of systemic chemotherapeutic agents: pegaspargase/dexamethasone/ methotrexate/ifosfamide/etoposide, pegaspargase/gemcitabine/oxaliplatin, pegaspargase/dexamethasone/cisplatin/ gemcitabine, pegaspargase/methotrexate/ dexamethasone	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 5 mg PO BID	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.; June 2025. Available at: https://www.bavencio.com/. Accessed October 23, 2025.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed November 30, 2025.
3. National Comprehensive Cancer Network. Merkel Cell Carcinoma Version 2.2026. Available at https://www.nccn.org/professionals/physician_gls/pdf/mcc.pdf.Accessed November 30, 2025.
4. National Comprehensive Cancer Network. Bladder Cancer Version 2.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/bladder.pdf. Accessed November 30, 2025.
5. National Comprehensive Cancer Network. Kidney Cancer Version 1.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf.Accessed November 30, 2025.
6. National Comprehensive Cancer Network. Gestational Trophoblastic Neoplasia Version 2.2026. Available at https://www.nccn.org/professionals/physician_gls/pdf/gtn.pdf. Accessed November 30, 2025.

7. National Comprehensive Cancer Network. Uterine Neoplasms Version 2.2026. Available at https://www.nccn.org/professionals/physician_gls/pdf/uterine.pdf. Accessed November 30, 2025.
8. National Comprehensive Cancer Network. Head and Neck Cancers Version 5.2025. Available at https://www.nccn.org/professionals/physician_gls/pdf/head-and-neck.pdf. Accessed November 30, 2025.
9. National Comprehensive Cancer Network. T-Cell Lymphomas Version 2.2025. Available at https://www.nccn.org/professionals/physician_gls/pdf/t-cell.pdf. Accessed November 30, 2025.
10. National Comprehensive Cancer Network. Thymomas and Thymic Carcinomas Version 1.2026. Available at https://www.nccn.org/professionals/physician_gls/pdf/thymic.pdf. Accessed November 30, 2025.

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
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	01/2023

Reviews, Revisions, and Approvals	Date
after a platinum-based regimen, and for RCC added the requirement for clear cell histology; references reviewed and updated.	
1Q 2024 annual review: per NCCN guidelines added coverage criteria for salivary gland tumors (category 2B recommendation); references reviewed and updated.	01/2024
1Q 2025 annual review: per NCCN guidelines added criteria for off-label use for thymic carcinoma and extranodal NK/T-cell lymphomas; for off-label use for salivary gland tumors, removed the requirement for combination use with Inlyta since Bavencio also has a 2A rec for use without Inlyta; references reviewed and updated.	01/2025
1Q 2026 annual review: for MCC, added disease qualifier of locally advanced per NCCN; for off label indications per NCCN, revised disease qualifiers for thymic carcinoma, added option for combination with Inlyta for endometrial carcinoma, and added requirement for combination with Inlyta for salivary gland tumors; revised initial approval durations from 6 months to 12 months; references reviewed and updated.	01/2026