Clinical Policy: Telisotuzumab Vedotin-tllv (Emrelis)

Reference Number: CP.PHAR.733
Effective Date: 09.01.25
Last Review Date: 08.25
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

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

Description

Telisotuzumab vedotin-tllv (Emrelis™) is a c-Met-directed antibody and microtubule inhibitor conjugate.

FDA Approved Indication(s)

Emrelis is indicated for the treatment of adult patients with locally advanced or metastatic non-squamous non-small cell lung cancer (NSCLC) with high c-Met protein overexpression [≥ 50% of tumor cells with strong (3+) staining], as determined by an FDA-approved test, who have received a prior systemic therapy.

This indication is approved under accelerated approval based on overall response rate (ORR) and duration of response (DOR). Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

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 Emrelis is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Non-Small Cell Lung Cancer (must meet all)**:**

1. Diagnosis of NSCLC;
2. Disease is recurrent, locally advanced, or metastatic;
3. Disease has all of the following characteristics (a, b, c, and d):
   a. Non-squamous;
   b. High c-Met/MET protein overexpression, defined as ≥ 50% of tumor cells;
   c. Strong (3+) immunohistochemistry staining (IHC 3+);
   d. Epidermal growth factor receptor (EGFR) wild-type;
4. Prescribed by or in consultation with an oncologist;
5. Age ≥ 18 years;
6. Member has received prior systemic therapy for NSCLC (*see Appendix B*);
7. Request is for single agent therapy;
8. Request meets one of the following (a or b):*
   a. Dose does not exceed 1.9 mg/kg, up to a maximum of 190 mg, every 2 weeks;

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 (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Non-Small Cell Lung Cancer (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Emrelis 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 1.9 mg/kg, up to a maximum of 190 mg, every 2 weeks;
   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:
Medicaid/HIM – 12 months
Commercial – 6 months or member's renewal date, whichever is longer

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 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 – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

DOR: duration of response
EGFR: epidermal growth factor receptor
FDA: Food and Drug Administration
IHC: immunohistochemistry staining
ORR: overall response rate

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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Examples of systemic therapy for advanced or metastatic NSCLC: • Keytruda®/carboplatin/pemetrexed • Keytruda/cisplatin/pemetrexed • Libtayo®/pemetrexed/(carboplatin or cisplatin) • Tecentriq®/carboplatin/paclitaxel/bevacizumab • Tecentriq/carboplatin/albumin-bound paclitaxele • Opdivo®/Yervoy® • Opdivo/Yervoy/pemetrexed/(carboplatin or cisplatin) • Imjudo®/Imfinfzi®/carboplatin/albumin-bound paclitaxel • Imjudo/Imfinfzi/(carboplatin or cisplatin)/pemetrexed • Bevacizumab/carboplatin/paclitaxel • Bevacizumab/carboplatin/pemetrexed	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose

• Bevacizumab/cisplatin/pemetrexed
• Carboplatin-combination therapy
  ○ Combination options include: albumin-bound paclitaxel, docetaxel, etoposide, gemcitabine, paclitaxel, or pemetrexed
• Cisplatin-combination therapy
  ○ Combinations options include: docetaxel, etoposide, gemcitabine, paclitaxel, or pemetrexed
• Gemcitabine/docetaxel
• Gemcitabine/vinorelbine
• Albumin-bound paclitaxel
• Docetaxel
• Gemcitabine
• Paclitaxel
• Pemetrexed		

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
NSCLC	1.9 mg/kg IV every 2 weeks until disease progression or unacceptable toxicity	190 mg every 2 weeks

VI. Product Availability

Lyophilized powder in single-dose vials: 20 mg, 100 mg

VII. References

1. Emrelis Prescribing Information. North Chicago, IL : AbbVie, Inc.; May 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761384s000lbl.pdf. Accessed June 4, 2025.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed June 4, 2025.
3. National Comprehensive Cancer Network. Non-Small Cell Lung Cancer Version 4.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed June 4, 2025.
4. Camidge DR, Bar J, Horinouchi H, et al. Telisotuzumab Vedotin Monotherapy in Patients With Previously Treated c-Met Protein-Overexpressing Advanced Nonsquamous *EGFR*-Wildtype Non-Small Cell Lung Cancer in the Phase II LUMINOSITY Trial. J Clin Oncol. 2024 Sep 1; 42(25): 3000-3011.

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
J9326	Injection, telisotuzumab vedotin-tllv, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	06.04.25	08.25
HCPCS code added [C9306], HCPCS code removed [C9399].	09.11.25	
HCPCS code updates: added [J9326], removed [C9306, J9999].	01.06.26	

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.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.