STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Imfinzi (durvalumab)
PAM-006

Iowa Medicaid Program:	Prior Authorization	**Effective Date:**	10/20/2017
Revision Number:	4	**Last Rev Date:**	01/19/2024
Reviewed By:	Medicaid Medical Director	**Next Rev Date:**	01/17/2025
Approved By:	Medicaid Clinical Advisory Committee	**Approved Date:**	11/27/2017

Overview

Medication:[1]	durvalumab
Brand Name:	Imfinzi®
Pharmacologic Category:	Programmed death-ligand 1 (PD-L1) blocking antibody
FDA-Approved Indication(s):	Indicated for the treatment of adult patients with: 1. Unresectable, stage III non-small cell lung cancer (NSCLC) whose disease has not progressed following concurrent platinum-based chemotherapy and radiation therapy. 2. Metastatic NSCLC with no sensitizing epidermal growth factor (EGFR) mutation or anaplastic lymphoma kinase (ALK) genomic tumor aberrations [in combination with tremelimumab-actl (Imjudo®) and platinum-based chemotherapy]. 3. Extensive-stage small cell lung cancer (ES-SCLC) (in combination with etoposide and either carboplatin or cisplatin). 4. Locally advanced or metastatic biliary tract cancer (in combination with gemcitabine and cisplatin). 5. Unresectable hepatocellular carcinoma (uHCC) (in combination with Imjudo®).
How Supplied:	• Injection: 500 mg/10 mL (50 mg/mL) solution in a single-dose vial • Injection: 120 mg/2.4 mL (50 mg/mL) solution is a single-dose vial
Dosage and Administration:	See *Appendix B*
Benefit Category:	Medical

Descriptive Narrative

Immune checkpoints refer to a set of immune-regulatory pathways which maintain self-tolerance, prevent autoimmunity, and mitigate collateral tissue damages. Programmed death protein 1 (PD-1) and its ligand programmed death-ligand 1 (PD-L1) are critical immune checkpoint proteins that responsible for negative regulation of the stability and the integrity of T-cell immune function.[2]

PD-L1 is part of a complex system of receptors and ligands that are involved in controlling T-cell activation. In normal tissue, PD-L1 is expressed on various types of cells, including T-cells

and B lymphocytes. The normal function of PD-L1 is to regulate the balance between T-cell activation and tolerance through interaction with 2 receptors, programmed death-1 (PD-1) and CD80. Cancer cells can use immune checkpoint pathways to escape from the anti-tumor immune attack. Since PD-L1 is also expressed by tumors, it acts at multiple sites to help tumors evade detection and elimination by the host immune system. In the lymph nodes, PD-L1 on antigen presenting cells (APCs) binding to PD-1 or CD80 on activated T-cells, delivers an inhibitory signal to the T-cell. Likewise, binding of CD80 on APCs to PD-L1 on T-cells leads to inhibitory signaling in the T-cell. These bidirectional interactions lead to further inhibition of T-cell activation and fewer activated T-cells in the circulation. In the tumor environment, PD-L1 expressed on tumor cells binds to PD-1 on activated T-cells reaching the tumor. This delivers an inhibitory signal to those T-cells, preventing them from killing the target tumor cells, and thus protecting the tumor from immune elimination.[3]

Durvalumab (Imfinzi®) is a human immunoglobulin G1 kappa (IgG1κ) monoclonal antibody that binds to PD-L1 and blocks the interaction of PD-L1 with PD-1 and CD80 (B7.1). Blockade of PD-L1/PD-1 and PD-L1/CD80 interactions releases the inhibition of immune responses, without inducing antibody dependent cell-mediated cytotoxicity (ADCC).[1]

Guidelines

As new and emerging therapies are rapidly coming to market, oncology treatment recommendations and guidelines are constantly changing. To keep up with these changes, the National Comprehensive Cancer Network (NCCN) publishes guidelines which are developed and updated by 60 individual panels, comprising over 1,660 clinicians and oncology researchers from the 31 NCCN Member Institutions.[4]

The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) are a work in progress that may be refined as often as new significant data becomes available. To view the most recent and complete version of the guidelines, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way.

The information referenced at the time of this policy writing/revision is from:

- NCCN Guidelines® for Non-Small Cell Lung Cancer (Version 5.2023 – November 8, 2023)[5]
- NCCN Guidelines® for Small Cell Lung Cancer (Version 2.2024 – November 21, 2023)[6]
- NCCN Guidelines® for Biliary Tract Cancers (Version 3.2023 – November 8, 2023)[7]
- NCCN Guidelines® for Hepatocellular Carcinoma (Version 2.2023 – September 14, 2023)[8]
- NCCN Guidelines® for Cervical Cancer (Version 1.2024 – September 20, 2023)[9]

Recommendation(s) for durvalumab (Imfinzi®) in non-small cell lung cancer (NSCLC)

(I) Molecular and biomarker-directed therapy for advanced or metastatic disease
- A. First-line Therapy
  - a. PD-L1 ≥ 50%
    - i. Adenocarcinoma, large cell, NSCLC NOS
      - 1. Imfinzi® + Imjudo® + carboplatin + albumin-bound paclitaxel: Category 2B, other recommended
      - 2. Imfinzi® + Imjudo® + (carboplatin or cisplatin) + pemetrexed: Category 2B, other recommended
    - ii. Squamous cell carcinoma
      - 1. Imfinzi® + Imjudo® + carboplatin + albumin-bound paclitaxel: Category 2B, other recommended
      - 2. Imfinzi® + Imjudo® + (carboplatin or cisplatin) + gemcitabine: Category 2B, other recommended
  - b. PD-L1 ≥ 1% – 49%
    - i. Adenocarcinoma, large cell, NSCLC NOS
      - 1. Imfinzi® + Imjudo® + carboplatin + albumin-bound paclitaxel: Category 1, other recommended
      - 2. Imfinzi® + Imjudo® + (carboplatin or cisplatin) + pemetrexed: Category 1, other recommended
    - ii. Squamous cell carcinoma
      - 1. Imfinzi® + Imjudo® + carboplatin + albumin-bound paclitaxel: Category 2A, other recommended
      - 2. Imfinzi® + Imjudo® + (carboplatin or cisplatin) + gemcitabine: Category 2A, other recommended
- B. Continuation Maintenance Therapy
  - a. PD-L1 ≥ 50%
    - i. Adenocarcinoma, large cell, NSCLC NOS
      - 1. Imfinzi® [a] + pemetrexed [b]: category 2A treatment option
    - ii. Squamous cell carcinoma
      - 1. Imfinzi® [a]: category 2A treatment option
  - b. PD-L1 ≥ 1% – 49%
    - i. Adenocarcinoma, large cell, NSCLC NOS
      - 1. Imfinzi® [a] + pemetrexed [b]: category 2A treatment option
    - ii. Squamous cell carcinoma
      - 1. Imfinzi® [a]: category 2A treatment option

(II) Systemic therapy for advanced or metastatic disease
- A. Adenocarcinoma, large cell, NSCLC NOS (PS 0–1) & no contraindications to PD-1 or PD-L1 inhibitors [c]
  - a. Imfinzi® + Imjudo® + carboplatin + albumin-bound paclitaxel: Category 2A, other recommended
  - b. Imfinzi® + Imjudo® + (carboplatin or cisplatin) + pemetrexed: Category 2A, other recommended
- B. Squamous cell carcinoma (PS 0–1) & no contraindications to PD-1 or PD-L1 inhibitors [c]
  - a. Imfinzi® + Imjudo® + carboplatin + albumin-bound paclitaxel: Category 2A, other recommended [d]
  - b. Imfinzi® + Imjudo® + (carboplatin or cisplatin) + gemcitabine: Category 2A, other recommended [d]

(III) Systemic therapy for advanced or metastatic disease – maintenance [e]
- A. Adenocarcinoma, large cell, NSCLC NOS (PS 0–2)
  - a. Imfinzi® [f] + pemetrexed [g]: category 2A treatment option
- B. Squamous cell carcinoma (PS 0–2)
  - a. Imfinzi® [f]: category 2A treatment option

a If tremelimumab-actl (Imjudo®) combination therapy given.
b If tremelimumab-actl + durvalumab + (carboplatin or cisplatin) + pemetrexed given.
c Contraindications for treatment with PD-1/PD-L1 inhibitors may include active or previously documented autoimmune disease and/or current use of immunosuppressive agents; some oncogenic drivers (i.e., *EGFR exon 19* deletion or *L858R*, *ALK* rearrangements) have been shown to be associated with less benefit from PD-1/PD-L1 inhibitors. [PD-1: programmed cell death protein 1, PD-L1: programmed cell ligand 1]
d If progression on PD-1/PD-L1 inhibitor, using a PD-1/PD-L1 inhibitor is not recommended.
e Patients should receive maintenance therapy for 2 years if they received front-line immunotherapy. Patients should receive maintenance therapy until progression if they received second-line immunotherapy.
f If Imjudo® combination therapy given.
g If Imfinzi® + Imjudo® + (carboplatin or cisplatin) + pemetrexed given.

Recommendation(s) for durvalumab (Imfinzi®) in small cell lung cancer (SCLC)
(I) Primary therapy for extensive-stage small cell lung cancer (ES-SCLC) [a] A. 21-day cycle: 4 cycles total [b] carboplatin on day 1 + Imfinzi® on day 1 + etoposide on days 1, 2, 3 ➡ After 4 cycles, start maintenance regimen 28-day cycle: durvalumab (Imfinzi®) on day 1 every 28 days — all category 1 [c, d, e] B. 21-day cycle: 4 cycles total [b] cisplatin on day 1 + Imfinzi® on day 1 + etoposide on days 1, 2, 3 ➡ After 4 cycles, start maintenance regimen 28-day cycle: durvalumab (Imfinzi®) on day 1 every 28 days — all category 1 [c, d, e]
[a] For transformation to SCLC from NSCLC, consider referral to a center with expertise. [b] Four cycles of therapy are recommended, but some patients may receive up to 6 cycles based on response and tolerability after 4 cycles. [c] Contraindications for treatment with PD-1/PD-L1 inhibitors may include active or previously documented autoimmune disease and/or concurrent use of immunosuppressive agents. [d] Included patients with asymptomatic untreated brain metastases. [e] Maintenance immunotherapy with either atezolizumab or durvalumab should continue until progression or intolerable toxicity.

Recommendation(s) for durvalumab (Imfinzi®) in biliary tract cancer (BTC)
(I) Primary treatment for unresectable and metastatic disease A. Durvalumab (Imfinzi®) + gemcitabine + cisplatin: Category 1 primary treatment [a, b] (II) Neoadjuvant Therapy [c] A. Durvalumab (Imfinzi®) + gemcitabine + cisplatin: Category 2A, other recommended regimen
[a] Durvalumab + gemcitabine + cisplatin is also a recommended treatment option for patients who developed recurrent disease > 6 months after surgery with curative intent and > 6 months after completion of adjuvant therapy. [b] For patients who have not been previously treated with a checkpoint inhibitor when used as subsequent-line therapy because there is a lack of data for use of immunotherapy in patients who have previously been treated with a checkpoint inhibitor. [c] The decision to use neoadjuvant therapy needs to be individualized and in close consultation with surgical oncologist and multidisciplinary team. A period of 2-6 months with reassessment every 2-3 months is reasonable. There are limited clinical trial data to define a standard regimen or definitive benefit. Clinical trial participation is encouraged. The listed regimens are extrapolated from the metastatic setting.

Recommendation(s) for durvalumab (Imfinzi®) in hepatocellular carcinoma
(I) First-line systemic therapy A. Durvalumab (Imfinzi®) + tremelimumab-actl (Imjudo®): Category 1, preferred regimen B. Durvalumab (Imfinzi®): Category 1, other recommended regimen

Recommendation(s) for durvalumab (Imfinzi®) in cervical cancer (off-label)
(I) Small cell NECC, recurrent or metastatic disease – first-line therapy [a] A. Cisplatin/etoposide + atezolizumab (or durvalumab) – Category 2A, other recommended regimen B. Carboplatin/etoposide + atezolizumab (or durvalumab) – Category 2A, other recommended regimen
NECC = neuroendocrine carcinoma of the cervix [a] If not used previously, these agents can be used as second-line or subsequent therapy as clinically appropriate.

NCCN Categories of Evidence and Consensus (all recommendations are category 2A unless otherwise indicated)	
Category 1	Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2A	Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2B	Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
Category 3	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

NCCN Categories of Preference (all recommendations are considered appropriate)	
Preferred intervention	Interventions that are based on superior efficacy, safety, and evidence; and, when appropriate, affordability.
Other recommended intervention	Other interventions that may be somewhat less efficacious, more toxic, or based on less mature data; or significantly less affordable for similar outcomes.
Useful in certain circumstances	Other interventions that may be used for select patient populations (defined with recommendation).

Eastern Cooperative Oncology Group (ECOG) Performance Status Scale[10]

Developed by the Eastern Cooperative Oncology Group (ECOG), now part of the ECOG-ACRIN Cancer Research Group, and published in 1982, the ECOG Performance Status Scale describes a patient's level of functioning in terms of their ability to care for themself, daily activity, and physical ability (walking, working, etc.). It is used by doctors and researchers to assess how a patient's disease is progressing, how the disease affects the daily living abilities of the patient and determine appropriate treatment and prognosis.

GRADE	ECOG PERFORMANCE STATUS [Synonyms: WHO/Zubrod score]
0	Fully active, able to carry on all pre-disease performance without restriction.
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.
2	Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours.
3	Capable of only limited self-care; confined to bed or chair more than 50% of waking hours.
4	Completely disabled; cannot carry on any self-care; totally confined to bed or chair.
5	Dead.

Criteria (Initial)

Prior authorization is required.

Unresectable Stage III Non-Small Cell Lung Cancer

Imfinzi® is considered medically necessary when **ALL** of the following are met:

1. Confirmed diagnosis of locally advanced, unresectable, Stage III non-small cell lung cancer (NSCLC); **AND**
2. Member has NOT had disease progression following treatment with concurrent platinum-based chemotherapy and radiation therapy; **AND**
3. Member is 18 years of age or older; **AND**
4. Prescribed by, or in consultation with, an oncologist; **AND**
5. Member has not received prior immune-mediated therapy (excluding therapeutic anticancer vaccines); **AND**
6. Member has a current Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1; **AND**
7. Request meets one of the following (a or b):
    a. Regimen prescribed does not exceed the FDA-approved maximum recommended dose; or
    b. Regimen is supported by clinical practice guidelines (i.e., must be recommended in the NCCN Guidelines®). Supporting clinical documentation must be provided with any request for which regimen prescribed does not align with FDA-approved labeling.

Metastatic Non-Small Cell Lung Cancer

Imfinzi® is considered medically necessary when **ALL** of the following are met:

1. Confirmed diagnosis of metastatic non-small cell lung cancer (mNSCLC); **AND**
2. Tumors do **NOT** have sensitizing epidermal growth factor receptor (EGFR) mutation or anaplastic lymphoma kinase (ALK) genomic tumor aberrations; **AND**
3. Member is 18 years of age or older; **AND**
4. Prescribed by, or in consultation with, an oncologist; **AND**
5. Member has not received prior immune-mediated therapy (excluding therapeutic anticancer vaccines); **AND**
6. Member has a current Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1; **AND**
7. Request meets one of the following (a or b):
    a. Regimen prescribed does not exceed the FDA-approved maximum recommended dose; or
    b. Regimen is supported by clinical practice guidelines (i.e., must be recommended in the NCCN Guidelines®). Supporting clinical documentation must be provided with any request for which regimen prescribed does not align with FDA-approved labeling.

Extensive-stage small cell lung cancer

Imfinzi® is considered medically necessary when **ALL** of the following are met:

1. Confirmed diagnosis of extensive-stage small cell lung cancer (ES-SCLC); **AND**
2. Member meets **ONE** of the following:
    a. Imfinzi® is being used as a first-line therapy in combination with etoposide and either cisplatin or carboplatin for 4 cycles; **OR**
    b. Member has completed the first 4 cycles and is receiving Imfinzi® as a single agent for maintenance after chemotherapy; **AND**
3. Member is 18 years of age or older; **AND**
4. Prescribed by, or in consultation with, an oncologist; **AND**
5. Member has not received prior immune-mediated therapy (excluding therapeutic anticancer vaccines); **AND**
6. Member has a current Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1; **AND**
7. Request meets one of the following (a or b):
    a. Regimen prescribed does not exceed the FDA-approved maximum recommended dose; or
    b. Regimen is supported by clinical practice guidelines (i.e., must be recommended in the NCCN Guidelines®). Supporting clinical documentation must be provided with any request for which regimen prescribed does not align with FDA-approved labeling.

Biliary Tract Cancer

Imfinzi® is considered medically necessary when **ALL** of the following are met:

1. Confirmed diagnosis of biliary tract cancer (BTC); **AND**
2. Member meets **ONE** of the following (a or b):
    a. Member has unresectable or metastatic BTC; **OR**
    b. Member has recurrent disease at least 6 months after surgery and at least 6 months after adjuvant therapy (chemotherapy and/or radiation); **AND**
3. Imfinzi® will be used in combination with cisplatin and gemcitabine; **AND**
4. Member is 18 years of age or older; **AND**
5. Prescribed by, or in consultation with, an oncologist; **AND**
6. Member has not received prior immune-mediated therapy (excluding therapeutic anticancer vaccines); **AND**
7. Member has a current Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1; **AND**
8. Request meets one of the following (a or b):
    a. Regimen prescribed does not exceed the FDA-approved maximum recommended dose; or
    b. Regimen is supported by clinical practice guidelines (i.e., must be recommended in the NCCN Guidelines®). Supporting clinical documentation must be provided with any request for which regimen prescribed does not align with FDA-approved labeling.

Hepatocellular Carcinoma

Imfinzi® is considered medically necessary when **ALL** of the following are met:

1. Confirmed diagnosis of unresectable hepatocellular carcinoma (uHCC); **AND**
2. Following a single initial dose of tremelimumab-actl (Imjudo®), Imfinzi® will be prescribed as a single agent; **AND**
3. Member is 18 years of age or older; **AND**
4. Prescribed by, or in consultation with, an oncologist; **AND**
5. Member has not received prior immune-mediated therapy (excluding therapeutic anticancer vaccines); **AND**
6. Member has a current Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1; **AND**
7. Request meets one of the following (a or b):
    a. Regimen prescribed does not exceed the FDA-approved maximum recommended dose; or
    b. Regimen is supported by clinical practice guidelines (i.e., must be recommended in the NCCN Guidelines®). Supporting clinical documentation must be provided with any request for which regimen prescribed does not align with FDA-approved labeling.

Cervical Cancer (off-label)

Imfinzi® is considered medically necessary when **ALL** of the following are met:

1. Confirmed diagnosis of persistent, recurrent, or metastatic small cell neuroendocrine carcinoma of the cervix (NECC); **AND**
2. Member has not received prior immune-mediated therapy (excluding therapeutic anticancer vaccines); **AND**
3. Prescribed by, or in consultation with, an oncologist; **AND**
4. Request meets one of the following (a or b):
    a. Regimen prescribed does not exceed the FDA-approved maximum recommended dose; or
    b. Regimen is supported by clinical practice guidelines (i.e., must be recommended in NCCN Guidelines®). Supporting clinical documentation must be provided with any request for which regimen prescribed does not align with FDA-approved labeling.

Criteria (Continuation – all above indications)

Imfinzi® is considered medically necessary for continuation of therapy when **ALL** of the following criteria are met:

1. Member is currently receiving medication through the Iowa Medicaid benefit or has previously met initial approval criteria; **AND**
2. Documentation of positive clinical response to therapy, as demonstrated by tumor response or lack of disease progression, and an acceptable toxicity profile; **AND**
3. Prescribed by, or in consultation with, an oncologist; **AND**
4. Request meets one of the following (a or b):
    a. Regimen prescribed does not exceed the FDA-approved maximum recommended dose; or
    b. Regimen is supported by clinical practice guidelines (i.e., must be recommended in the NCCN Guidelines®). Supporting clinical documentation must be provided with any request for which regimen prescribed does not align with FDA-approved labeling; **AND**
5. ***For Stage III NSCLC only:*** Member has completed less than the maximum 12 months of therapy with Imfinzi® (if criteria 1-4 are met, may approve continued coverage for stage III NSCLC treatment for up to the maximum allowed duration of 12 months).

Approval Duration and Quantity Limits

Indication *	Quantity Limits		Approval Duration
NSCLC	≥ 30 kg:	10 mg/kg every 2 weeks OR 1,500 mg every 4 weeks	Initial: 6 months Continuation: maximum 12 total months of therapy
	< 30 kg:	10 mg/kg every 2 weeks	
mNSCLC	≥ 30 kg:	1,500 mg every 3 weeks (21 days) for 4 cycles, followed by 1,500 mg every 4 weeks (28 days)	Initial: 6 months Continuation: 12 months
	< 30 kg:	20 mg/kg every 3 weeks (21 days) for 4 cycles, followed by 20 mg/kg every 4 weeks (28 days)	
ES-SCLC	≥ 30 kg:	1,500 mg (in comb. with chemotherapy) every 3 weeks (21 days) for 4 cycles, followed by 1,500 mg every 4 weeks as a single agent	Initial: 6 months Continuation: 12 months
	< 30 kg:	20 mg/kg (in comb. with chemotherapy) every 3 weeks (21 days) for 4 cycles, followed by 10 mg/kg every 2 weeks as a single agent	
BTC	≥ 30 kg:	1,500 mg every 3 weeks (21 days) for up to 8 cycles, followed by 1,500 mg every 4 weeks (28 days)	Initial: 6 months Continuation: 12 months
	< 30 kg:	20 mg/kg every 3 weeks (21 days) for up to 8 cycles, followed by 20 mg/kg every 4 weeks (28 days)	
uHCC	≥ 30 kg:	1,500 mg every 4 weeks (28 days)	Initial: 6 months Continuation: 12 months
	< 30 kg:	20 mg/kg every 4 weeks (28 days)	

* **BTC:** locally advanced or metastatic biliary tract cancer **ES-SCLC:** extensive-stage small cell lung cancer
mNSCLC: metastatic non-small cell lung cancer **NSCLC:** unresectable, stage III non-small cell lung cancer
uHCC: unresectable hepatocellular carcinoma

Coding and Product Information

The following list(s) of codes and product information are provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS code is inappropriate.

HCPCS	Description
J9173	Injection, durvalumab, 10 mg

ICD-10	Description
C22.0	Liver cell carcinoma
C24.0 – C24.9	Malignant neoplasm of biliary tract (includes the extrahepatic bile duct, ampulla of Vater, overlapping sites of biliary tract, and biliary tract, unspecified)
C34.00 – C34.92	Malignant neoplasm of bronchus and lung

NDC (Strength)	Labeler	Dosage	Pkg Size	Pkg Qty	Units/Pkg
00310-4500-12 (120 mg/2.4 mL)	AstraZeneca Pharmaceuticals LP	10 mg	1	EA	12
00310-4611-50 (500 mg/10 mL)	AstraZeneca Pharmaceuticals LP	10 mg	1	EA	50

Appendix A: General Information

Previous indication for urothelial carcinoma: On May 1, 2017, the FDA granted accelerated approval to durvalumab (Imfinzi®, AstraZeneca UK Limited) for the treatment of patients with locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy or who have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy. Approval was based on promising results from the Phase I/II trial, with continued approval contingent on results from the DANUBE Phase III trial in the first-line metastatic bladder cancer setting. On February 19, 2021, AstraZeneca voluntarily withdrew this indication after the Phase III trial failed to meet its primary endpoints in 2020.[11]

Appendix B: Dosing and Administration

NSCLC: unresectable, stage III non-small cell lung cancer

mNSCLC: metastatic non-small cell lung cancer

BTC: locally advanced or metastatic biliary tract cancer

ES-SCLC: extensive-stage small cell lung cancer

uHCC: unresectable hepatocellular carcinoma

Imfinzi® as a single agent			
Indication		Recommended Dosage	Duration of Therapy
Stage III NSCLC	≥ 30 kg	10 mg/kg every 2 weeks OR 1,500 mg every 4 weeks	Until disease progression, unacceptable toxicity, or a maximum of 12 months
	< 30 kg	10 mg/kg every 2 weeks	

Imfinzi® in combination with Imjudo® and platinum-based chemotherapy				
Indication – Metastatic NSCLC				
DOSAGE	**Tumor Histology**	**Patient Weight**	**Imfinzi Dosage**	**Imjudo Dosage**	**Platinum-based chemotherapy regimen** [a]
	Non-Squamous	≥ 30 kg	1,500 mg	75 mg	• carboplatin & nabpaclitaxel (Abraxane®) OR • carboplatin or cisplatin & pemetrexed (Alimta®)
		< 30 kg	20 mg/kg	1 mg/kg	
	Squamous	≥ 30 kg	1,500 mg	75 mg	• carboplatin & nabpaclitaxel (Abraxane®) OR • carboplatin or cisplatin & gemcitabine
		≤ 30 kg	20 mg/kg	1 mg/kg	

SCHEDULE	**Week** [b, c]	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
	Cycle:	1			2			3			4			5				6				7				8
	Imjudo [d]	X			X			X			X							X								
	Imfinzi [b]	X			X			X			X			X				X				X				X
	Chemotherapy	X			X			X			X			X[e]				X[e]				X[e]				X[e]

[a] Refer to product prescribing information for dosing information on platinum-based chemotherapy regimens.
[b] Continue Imfinzi until disease progression.
[c] Dosing interval change from every 3 weeks to every 4 weeks starting at cycle 5.
[d] If patients receive fewer than 4 cycles of platinum-based chemotherapy, the remaining cycles of Imjudo (up to a total of 5) should be given after the platinum-based chemotherapy phase, in combination with durvalumab, every 4 weeks.
[e] Optional pemetrexed therapy from week 12 until disease progression or intolerable toxicity for patients with non-squamous disease who received treatment with pemetrexed and carboplatin/cisplatin.

Imfinzi® in combination with other therapeutic agents			
Indication		Recommended Dosage	Duration
ES-SCLC	≥ 30 kg	1,500 mg in combination with chemotherapy* every 3 weeks (21 days) for 4 cycles, followed by 1,500 mg every 4 weeks as a single agent	Until disease progression or unacceptable toxicity
	< 30 kg	20 mg/kg in combination with chemotherapy* every 3 weeks (21 days) for 4 cycles, followed by 10 mg/kg every 2 weeks as a single agent	
BTC	≥ 30 kg	1,500 mg in combination with chemotherapy* every 3 weeks (21 days) for up to 8 cycles, followed by 1,500 mg every 4 weeks as a single agent	
	< 30 kg	20 mg/kg in combination with chemotherapy* every 3 weeks (21 days) for up to 8 cycles, followed by 20 mg/kg every 4 weeks as a single agent	
uHCC	≥ 30 kg	1,500 mg following a single dose of Imjudo®† 300 mg at Day 1 of Cycle 1; continue Imfinzi® 1,500 mg as a single agent every 4 weeks	
	< 30 kg	20 mg/kg following a single dose of Imjudo®† 4 mg/kg at Day 1 of Cycle 1; continue Imfinzi® 20 mg/kg as a single agent every 4 weeks	

* Administer Imfinzi® prior to chemotherapy on the same day. Refer to the prescribing information for the agent administered in combination with Imfinzi® for recommended dosage information, as appropriate.
† Administer Imjudo® (tremelimumab-actl) prior to Imfinzi® on the same day. When Imjudo® is administered in combination with Imfinzi®, refer to the prescribing information for tremelimumab-actl dosing information.

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving, and Iowa Medicaid reserves the right to review and update medical policy on an annual or as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. Medical necessity guidelines are developed for selected physician-administered medications found to be safe and proven to be effective in a limited, defined population or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

[1] Imfinzi prescribing information (06/2023). AstraZeneca Pharmaceuticals LP: Wilmington, DE. Available online at www.imfinzihcp.com. Accessed December 5, 2023.

[2] Ghosh C, Luong G, Sun Y. A snapshot of the PD-1/PD-L1 pathway. J Cancer. 2021 Mar 5;12(9):2735-2746. PMID 33854633.

[3] A Phase III, Randomised, Double-blind, Placebo-controlled, Multi-centre, International Study of MEDI4736 as Sequential Therapy in Patients With Locally Advanced, Unresectable Non-Small Cell

Lung Cancer (Stage III) Who Have Not Progressed Following Definitive, Platinum-based, Concurrent Chemoradiation Therapy (PACIFIC). ClinicalTrials.gov identifier: NCT02125463. Updated November 10, 2022. clinicaltrials.gov/ct2/show/NCT02125461. Accessed January 4, 2023.

[4] National Comprehensive Cancer Network (NCCN). Development and Update of Guidelines. Available online at www.nccn.org. Accessed October 11, 2023.

[5] Referenced from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Non-Small Cell Lung Cancer (v.5.2023 – November 8, 2023). Accessed December 5, 2023. The NCCN Guidelines® are a work in progress that may be refined as often as new significant data becomes available. To view the most recent and complete version of the guidelines, go online to NCCN.org.

[6] Referenced from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Small Cell Lung Cancer (v.2.2024 – November 21, 2023). Accessed December 5, 2023. The NCCN Guidelines® are a work in progress that may be refined as often as new significant data becomes available. To view the most recent and complete version of the guidelines, go online to NCCN.org.

[7] Referenced from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Biliary Tract Cancers (v.3.2023 – November 8, 2023). The NCCN Guidelines® are a work in progress that may be refined as often as new significant date becomes available. To view the most recent and complete version of the guidelines, go online to NCCN.org.

[8] Referenced from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Hepatocellular Carcinoma (v.2.2023 – September 14, 2023). Accessed December 5, 2023. The NCCN Guidelines® are a work in progress that may be refined as often as new significant data becomes available. To view the most recent and complete version of the guidelines, go online to NCCN.org.

[9] Referenced from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Cervical Cancer (v.1.2024 – September 20, 2023). Accessed December 5, 2023. The NCCN Guidelines® are a work in progress that may be refined as often as new significant data becomes available. To view the most recent and complete version of the guidelines, go online to NCCN.org.

[10] Oken M, Creech R, Tormey D, et al. Toxicity and response criteria of the Eastern Cooperative Oncology Group. Am J Clin Oncol. 1982;5:649-655. PMID 7165009.

[11] AstraZeneca Press Release. Voluntary withdrawal of Imfinzi indication in advanced bladder cancer in the US. Published on February 22, 2021. Available online at www.astrazeneca.com/media-centre/press-releases/2021/voluntary-withdrawal-imfinzi-us-bladder-indication.html. Accessed January 12, 2022.

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]	CAC		
Signature			

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]	CAC		
Signature			

Change Date	Changed By	Description of Change	Version
01/19/2024	CAC	Updated NCCN Guidelines (Hepatobiliary Cancers split into Biliary Tract Cancers and Hepatocellular Carcinoma). Added NCCN Guidelines and clinical criteria for cervical cancer (off-label indication). Combined NSCLC criteria under one header (previously split into "Unresectable, Stage III" and "Metastatic"). Combined Quantity Limits and Duration Approval into one table.	4
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
01/20/2023	CAC	Added overview of PD-1/PD-L1 pathway in Descriptive Narrative. Added criteria for new indications: biliary tract cancer (FDA-approved 9/2/22); hepatocellular carcinoma (FDA-approved 10/21/22); metastatic NSCLC (FDA-approved 11/10/22). Updated NCCN Guidelines. Moved Dosage and Administration out of Overview table into a separate section (Appendix B).	3
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
01/21/2022	CAC	Removed metastatic urothelial carcinoma indication. Updated criteria. Added and formatted new sections/text. Updated references.	2
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
11/27/2017	Medical Director	Criteria implementation.	1
Signature C. David Smith, MD			

CAC = Medicaid Clinical Advisory Committee