Clinical Policy Title:	polatuzumab vedotin-piiq
Policy Number:	RxA.251
Drug(s) Applied:	Polivy®
Original Policy Date:	02/07/2020
Last Review Date:	06/10/2021
Line of Business Policy Applies to:	All lines of business

Background

Polatuzumab vedotin-piiq (Polivy®) is a CD79b-directed antibody-drug conjugate with activity against dividing B-cells. Polivy® is indicated in combination with bendamustine and a rituximab product for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified (NOS), after at least two prior therapies.

Accelerated approval was granted for this indication based on complete response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
Polatuzumab Vedotin-piiq (Polivy®)	DLBCL	1.8 mg/kg IV over 90 minutes every 21 days for 6 cycles in combination with bendamustine and a rituximab product. *(Administer Polivy®, bendamustine, and rituximab product in any order on Day 1 of each cycle.)* • Bendamustine: The recommended dose of bendamustine is 90 mg/m^2/day IV on Day 1 and 2 when administered with Polivy® and a rituximab product. • Rituximab product: The recommended dose of rituximab product is 375 mg/m^2 IV on Day 1 of each cycle.	1.8 mg/kg (Polivy®) every 21 days

Dosage Forms

- Single-dose vial for injection after reconstitution: 140 mg and 30 mg

Clinical Policy

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria. The provision of provider samples does not guarantee coverage under the provisions of the pharmacy benefit administered by RxAdvance. All criteria for initial approval must be met in order to obtain coverage.

I. Initial Approval Criteria

A. Diffuse Large B-Cell Lymphoma (must meet all):

1. Diagnosis of DLBCL (see *Appendix D for DLBCL subtypes*);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Member is not a candidate for allogeneic or autologous stem cell transplant;
5. Disease is relapsed or refractory;
6. Member has received ≥ 2 prior therapies (*prior therapies can include a first-line and second-line/subsequent therapy, see Appendix B for examples of prior therapies*);
7. Polivy® is prescribed in combination with bendamustine and a rituximab product (see *Appendix B for rituximab products*);
   **Prior authorization is required for bendamustine and rituximab products*
8. Request meets one of the following (a or b):
   a. Dose does not exceed 1.8 mg/kg on Day 1 of a 21-day cycle, for a maximum of 6 cycles;
   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
Commercial: 6 months
Medicaid: 6 months

B. NCCN Recommended Uses (off-label) (must meet all):

1. Diagnosis of one of the following (a, b, c, d, e, or f):
   a. High-grade B-cell lymphoma (HGBL);
   b. Follicular lymphoma (FL) (grade 1-2);
   c. Mantle cell lymphoma;
   d. Monomorphic post-transplant lymphoproliferative disorder (B-cell type);
   e. One of the following AIDS-related B-cell lymphoma subtypes (i, ii, iii, or iv):
      i. AIDS-related DLBCL;
      ii. Primary effusion lymphoma;
      iii. HHV8-positive diffuse large B-cell lymphoma, NOS;
      iv. AIDS-related plasmablastic lymphoma;
   f. Histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. For HGBL or AIDS-related B-cell lymphoma, member is not a candidate for allogeneic or autologous stem cell transplant;
5. Member meets one of the following (a or b):
   a. For FL, member has received ≥ 1 prior therapy (see Appendix B);
   b. For all other indications, member has received ≥ 2 prior therapies;
6. Polivy® is prescribed as a single agent or in combination with bendamustine* and/or a rituximab product* (see Appendix B for rituximab products);

**Prior authorization may be required for bendamustine and rituximab products*

7. Dose is within FDA maximum limit for any FDA-approved indication or 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
Commercial: 6 months
Medicaid: 6 months

II. Continued Therapy Approval

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

1. Member is currently receiving medication that has been authorized by RxAdvance or documentation supports that member is currently receiving Polivy® for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. Member has received < 6 cycles of Polivy®;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 1.8 mg/kg on Day 1 of a 21-day cycle, for a maximum of 6 cycles;
   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
Commercial: 12 months
Medicaid: 12 months

III. Appendices

APPENDIX A: Abbreviation/Acronym Key
DLBCL: diffuse large B-cell lymphoma
FDA: Food and Drug Administration
NOS: not otherwise specified
HGBL: High grade B-cell lymphoma
FL: Follicular lymphoma
HHV8: Human herpesvirus 8
NCCN: National Comprehensive Cancer Network

APPENDIX B: Therapeutic Alternatives
Below are suggested therapeutic alternatives based on clinical guidance. Please check drug formulary for preferred agents and utilization management requirements.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Rituximab Products		
Rituxan®(rituximab), Truxima®(rituximab-abbs), Rituxan Hycela®(rituximab-hyaluronidase)	Varies	Varies
Diffuse Large B-Cell Lymphoma: Examples of ≥ 2 Prior Therapies can include a First-Line and Second-Line/Subsequent Regimen		

First-Line Treatment Regimens (per NCCN)		
RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone)	Varies	Varies
RCEPP (rituximab, cyclophosphamide, etoposide, prednisone, procarbazine)	Varies	Varies
RCDOP (rituximab, cyclophosphamide, liposomal doxorubicin, vincristine, prednisone)	Varies	Varies
DA-EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicine) + rituximab	Varies	Varies
RCEOP (rituximab, cyclophosphamide, etoposide, vincristine, prednisone)	Varies	Varies
RGCVP (rituximab, gemcitabine, cyclophosphamide, vincristine, prednisone)	Varies	Varies
Second-Line Treatment (per NCCN for Relapsed or Refractory Disease) – Examples of Regimens for Non-Candidates for Transplant		
bendamustine ± rituximab	Varies	Varies
CEPP (cyclophosphamide, etoposide, prednisone, procarbazine) ± rituximab	Varies	Varies
CEOP (cyclophosphamide, etoposide, vincristine, prednisone) ± rituximab	Varies	Varies
DA-EPOCH ± rituximab	Varies	Varies
GDP (gemcitabine, dexamethasone, carboplatin) ± rituximab	Varies	Varies
GemOx (gemcitabine, oxaliplatin) ± rituximab	Varies	Varies
gemcitabine, vinorelbine ± rituximab	Varies	Varies
ibrutinib	Varies	Varies
lenalidomide ± rituximab	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

- Contraindication(s):
  - None.

- Boxed Warning(s):
  - None.

APPENDIX D: General Information

- In addition to the FDA-approved DLBCL, NOS subtype, other DLBCL subtypes provided by NCCN include, but are not limited to the following:

- DLBCL, NOS
  - HGBL with translocations of MYC and BCL2 and/or BCL6
  - HGBL, NOS
- DLBCL coexistent with follicular lymphoma of any grade
- DLBCL coexistent with gastric MALT lymphoma
- DLBCL coexistent with nongastric MALT lymphoma
- Follicular lymphoma grade 3
- Intravascular large B-cell lymphoma
- DLBCL associated with chronic inflammation
- ALK-positive DLBCL
- EBV-positive DLBCL, NOS
- T-cell/hitiocyte-rich large B-cell lymphoma
- DLBCL with IRF4/MUM1 rearrangement

References

1. Polivy Prescribing Information. South San Francisco, CA: Genentech, Inc.; September 2020. Available at: https://www.gene.com/download/pdf/polivy_prescribing.pdf. Accessed May 5, 2021.
2. Data on file. Genentech, Inc.; South San Francisco, CA. Polivy in the treatment of relapsed or refractory diffuse large B-cell lymphoma (GO29365 Trial).
3. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed May 5, 2021.
4. National Comprehensive Cancer Network. B-Cell Lymphomas Version 2.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed May 5, 2021.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	02/07/2020
Policy was reviewed: 1. Clinical Policy Title was updated. 2. Drug(s) Applied was updated. 3. Line of Business Policy Applies to was update to all lines of business. 4. Continued Therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance..." 5. Initial Approval criteria: Commercial, Medicaid and HIM approval duration were updated to 6 months. 6. Continued Approval criteria: Commercial, Medicaid and HIM approval duration were updated to 12 months. 7. Updated APPENDIX A: Abbreviation/Acronym Key to include HGBL - High grade B-cell	07/15/2020	09/14/2020

lymphoma. 8. References were updated. 9. Updated Dosing Information for Maximum Dose – added “every 21 days”		
Policy was reviewed: 1. Statement about provider sample, ‘‘The provision of provider samples does not guarantee coverage…” was added to Clinical Policy. 2. Appendix B: Statement under Therapeutic Alternatives was changed to “Below are suggested therapeutic alternatives based on...”. 3. Dosage form section was updated to include 30mg vial. 4. Initial and continuation approval criteria: off-label indication criteria were added. 5. HIM approval duration was removed from Initial and continued approval criteria. 6. Appendix A: Updated for HHVB8 and NCCN. 7. Appendix B: Therapeutic Alternatives header verbiage has been changed to “Below are suggested therapeutic alternatives based on...” 8. References were updated.	05/05/2021	06/10/2021