Clinical Policy Title:	durvalumab
Policy Number:	RxA.393
Drug(s) Applied:	Imfinzi®
Original Policy Date:	03/06/2020
Last Review Date:	06/10/2021
Line of Business Policy Applies to:	All lines of business

Background

Durvalumab (Imfinzi®) is a programmed death-ligand 1 (PD-L1) blocking antibody and is indicated for the treatment of adult patients with:

- Unresectable, stage III non-small cell lung cancer (NSCLC) whose disease has not progressed following concurrent platinum-based chemotherapy and radiation therapy; or
- In combination with etoposide and either carboplatin or cisplatin, as first-line treatment of extensive-stage small cell lung cancer (ES-SCLC).

On February 19, 2021, the FDA the removal of the accelerated approval for the indication of the treatment of adult patients with locally advanced or metastatic urothelial cancer.

Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
durvalumab (Imfinzi®)	NSCLC	Weight 30 kg and more: 10 mg/kg every 2 weeks or 1500 mg every 4 weeks Weight less than 30 kg: 10 mg/kg every 2 weeks Continue until disease progression or unacceptable toxicity or a maximum of 12 months.	10 mg/kg IV every 2 weeks or 1,500 mg IV every 4 weeks
	ES-SCLC	With etoposide and either carboplatin or cisplatin: Weight 30 kg and more: 1500 mg every 3 weeks in combination with chemotherapy for 4 cycles, and then 1500 mg every 4 weeks as a single agent. Weight less than 30 kg: 20 mg/kg every 3 weeks in combination with chemotherapy for 4 cycles, and then 10 mg/kg every 2 weeks as a single agent. Continue until disease progression or unacceptable toxicity.	1,500 mg IV every 3 or 4 weeks

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

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Dosage Forms

- Single-dose vials: 120 mg/2.4 mL, 500 mg/10 mL solution in a single-dose vial

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

1. Member has one of the following diagnoses (a or b):
   a. Diagnosis of unresectable stage III NSCLC; or
   b. Diagnosis of unresectable stage II NSCLC (off-label);
2. Prescribed by or in consultation with an oncologist;
3. Member is 18 years of age or older;
4. Disease has not progressed following concurrent platinum-based chemotherapy and radiation therapy;
5. Durvolumab is being used as consolidation therapy (*see Appendix D for definition*);
6. Member has not previously received treatment with another anti-PD-1 or anti-PD-L1 agent;
7. Member is not receiving therapy for an autoimmune disease or chronic condition requiring treatment with systemic immunosuppressant therapy;
8. Request meets one of the following (a or b):*
   a. Dose does not exceed 10 mg/kg IV every 2 weeks or 1,500 mg IV every 4 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

Commercial: 6 months

Medicaid: 6 months

B. Extensive-Stage Small Cell Lung Cancer (must meet all):

1. Diagnosis of ES-SCLC;
2. Prescribed by or in consultation with an oncologist;
3. Member is 18 years of age or older;
4. Durvolumab is being used as first line therapy and is prescribed in combination with etoposide and either carboplatin or cisplatin for 4 cycles then durvolumab is used as monotherapy;
5. Member has not previously received treatment with another anti-PD-1 or anti-PD-L1 agent;
6. Member is not receiving therapy for an autoimmune disease or chronic condition requiring treatment with systemic immunosuppressant therapy;
7. Request meets one of the following (a or b):*
   a. Dose does not exceed 1,500 mg IV every 3 or 4 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.*

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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 member has previously met initial approval criteria listed in this policy.
2. Member is currently receiving durvalumab for a covered indication and has received this medication for at least 30 days;
3. Member is responding positively to therapy;
4. If request is for a dose increase, request meets one of the following (a or b):
   a. NSCLC: New dose does not exceed 10 mg/kg IV every 2 weeks or 1,500 mg IV every 4 weeks;
   b. ES-SCLC: New dose does not exceed 1,500 mg IV every 3 or 4 weeks;
   c. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration
NSCLC
Commercial: up to but not to exceed 12 months
Medicaid: up to but not to exceed 12 months
ES-SCLC
Commercial: 12 months
Medicaid: 12 months

III. Appendices

APPENDIX A: Abbreviation/Acronym Key
ES-SCLC: Extensive-Stage Small Cell Lung Cancer
FDA: Food and Drug Administration
HSCT: Hematopoietic stem cell transplantation
NSCLC: Non-Small Cell Lung Cancer
RT: Radiation therapy
PD: Programmed DeathPD-L1: Programmed Death-Ligand 1

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
NSCLC (examples of concurrent platinum-containing/radiotherapy regimens)		
cisplatin, etoposide, RT	Varies	Varies
carboplatin, pemetrexed, RT	Varies	Varies
paclitaxel, carboplatin, RT	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.

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APPENDIX C: Contraindications/Boxed Warnings

- Contraindication(s):
  - None reported.

- Boxed Warning(s):
  - None reported.

APPENDIX D: General Information

- Immune-Mediated Adverse Reactions
  - Immune-mediated adverse reactions, which may be severe or fatal, can occur in any organ system or tissue, including the following: immune-mediated pneumonitis, immune-mediated colitis, immune-mediated hepatitis, immune-mediated endocrinopathies, immune-mediated dermatologic adverse reactions, immune-mediated nephritis and renal dysfunction, and solid organ transplant rejection.
  - Monitor for early identification and management. Evaluate liver enzymes, creatinine, and thyroid function at baseline and periodically during treatment.
  - Withhold or permanently discontinue based on severity and type of reaction.
- Infusion-Related Reactions: Interrupt, slow the rate of infusion, or permanently discontinue Imfinzi® based on the severity of the reaction.
- Complications of Allogeneic HSCT: Fatal and other serious complications can occur in patients who receive allogeneic HSCT before or after being treated with a PD-1/PD-L1 blocking antibody.
- Embryo-Fetal Toxicity: Can cause fetal harm. Advise females of reproductive potential of the potential risk to a fetus and use of effective contraception.
- The use of durvalumab in unresectable stage II NSCLC is a NCCN category 2A recommendation.
- Consolidation therapy is defined as any drug or medical treatment that is used to kill any remaining cancer cells.

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Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	03/06/2020
Policy updated. 1. Formatting updated. 2. Policy Title updated. 3. New indication and criteria added. 4. Continued criteria for approval updated. 5. Approval duration updated. 6. Reference updated.	07/23/2020	09/14/2020
Policy was reviewed: 1. Clinical Policy title was updated. 2. Background was updated. 3. Dosing Information was updated. 4. Initial Approval criteria was updated. 5. Continued Therapy approval criteria was updated. 6. Continued Therapy criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance..." 7. Appendix A and D were updated. 8. References were reviewed and updated.	03/31/2021	06/10/2021

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