Clinical Policy: Tremelimumab-actl (Imjudo)

Reference Number: CP.PHAR.612
Effective Date: 03.01.23
Last Review Date: 02.25
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

Tremelimumab-actl (Imjudo®) is a cytotoxic T-lymphocyte-associated antigen 4 (CTLA-4) blocking antibody.

FDA Approved Indication(s)

Imjudo is indicated for the treatment of:

- In combination with durvalumab, for the treatment of adult patients with unresectable hepatocellular carcinoma (uHCC);
- In combination with durvalumab and platinum-based chemotherapy for the treatment of adult patients with metastatic non-small cell lung cancer (NSCLC) with no sensitizing epidermal growth factor receptor (EGFR) mutation or anaplastic lymphoma kinase (ALK) genomic tumor aberrations.

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 Imjudo 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 recurrent, advanced, or metastatic NSCLC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed in combination with durvalumab and platinum-based therapy *(see Appendix D)* as one of the following (a-k):*
   **Prior authorization may be required.*
   a. First-line therapy for disease without sensitizing EGFR mutations, ALK genomic tumor aberrations, or other actionable molecular biomarkers (e.g., KRAS, ROS1, BRAF, NTRK1/2/3, MET, RET, ERBB2 (HER2) – note: may be KRAS G12C mutation positive) (see *Appendix D)*;
   b. First-line therapy for EGFR exon 20 insertion mutation positive disease;
   c. First-line or subsequent therapy for BRAF V600E mutation positive tumors;
   d. First-line or subsequent therapy for NRTK1/2/3 gene fusion positive tumors;
   e. First-line or subsequent therapy for MET exon 14 skipping mutation positive tumors;

f. First-line or subsequent therapy for RET rearrangement positive tumors;
g. First-line therapy for ERBB2 (HER2) mutation positive tumors;
h. Subsequent therapy for EGFR exon 19 deletion or exon 21 L858R tumors and prior erlotinib (with or without ramucirumab or bevacizumab), afatinib, gefitinib, osimertinib, amivantamab-vmjw + lazertinib, or dacomitinib therapy;
i. Subsequent therapy for EGFR S768I, L861Q, and/or G719X mutation positive tumors and prior afatinib, osimertinib, erlotinib, gefitinib, or dacomitinib therapy;
j. Subsequent therapy for ALK rearrangement positive tumors and prior crizotinib, ceritinib, alectinib, brigatinib, or lorlatinib therapy;
k. Subsequent therapy for ROS1 rearrangement positive tumors and prior crizotinib, entrectinib, repotrectinib, ceritinib, or lorlatinib therapy;

5. Request meets one of the following (a, b, or c):*
   a. For body weight < 30 kg, dose does not exceed Imjudo 1 mg/kg every 3 weeks in combination with durvalumab 20 mg/kg and platinum-based chemotherapy for 4 cycles, and then durvalumab 20 mg/kg every 4 weeks as a single agent with histology-based pemetrexed therapy every 4 weeks, and a fifth dose of Imjudo 1 mg/kg in combination with durvalumab dose 6 at week 16;
   b. For body weight ≥ 30 kg, dose does not exceed Imjudo 75 mg every 3 weeks in combination with durvalumab 1,500 mg and platinum-based chemotherapy for 4 cycles, and then durvalumab 1,500 mg every 4 weeks as a single agent with histology-based pemetrexed therapy every 4 weeks, and a fifth dose of Imjudo 75 mg in combination with durvalumab dose 6 at week 16;
   c. 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. Hepatocellular Carcinoma (must meet all)**:**

1. Diagnosis of unresectable, liver-confined, or metastatic hepatocellular carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed in combination with durvalumab;*

   **Prior authorization may be required.*

5. Request meets one of the following (a, b, or c):*
   a. For body weight < 30 kg, dose does not exceed 4 mg/kg as a single dose in combination with durvalumab 20 mg/kg at Cycle 1/Day 1, followed by durvalumab as a single agent every 4 weeks;
   b. For body weight ≥ 30 kg, dose does not exceed, 300 mg as a single dose in combination with durvalumab 1,500 mg at Cycle 1/Day 1, followed by durvalumab as a single agent every 4 weeks;
   c. Dose 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 (one dose)

C. Gastric, Esophageal, and Esophagogastric Junction Cancer (off-label) (must meet all):
1. Diagnosis of gastric, esophageal, or esophagogastric junction adenocarcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed in combination with durvalumab as neoadjuvant therapy;*
   **Prior authorization may be required.*
5. Disease is microsatellite instability-high (MSI-H) or deficient mismatch repair (dMMR);
6. Provider attestation that member is medically fit for surgery;
7. Request meets one of the following (a or b):*
   a. Dose is within FDA approved maximum recommended dose;
   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

D. 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. Hepatocellular Carcinoma
1. Re-authorization is not permitted.

Approval duration: Not applicable

B. All Other Indications in Section I (must meet all):
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Imjudo 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 either of the following (a or b):*
   a. For metastatic NSCLC (i or ii):

i. For body weight < 30 kg, new dose does not exceed 1 mg/kg every 3 weeks in combination with durvalumab 20 mg/kg and platinum-based chemotherapy for 4 cycles and a fifth dose of Imjudo 1 mg/kg in combination with durvalumab dose 6 at week 16;
ii. For body weight ≥ 30 kg, new dose does not exceed 75 mg every 3 weeks in combination with durvalumab 1,500 mg and platinum-based chemotherapy for 4 cycles, and a fifth dose of Imjudo 75 mg in combination with durvalumab dose 6 at week 16;

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 to the member's renewal date, whichever is longer

C. 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 2 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

ALK: anaplastic lymphoma kinase
dMMR: deficient mismatch repair
EGFR: epidermal growth factor receptor
FDA: Food and Drug Administration
MSI-H: microsatellite instability-high
NSCLC: non-small cell lung cancer
uHCC: unresectable hepatocellular carcinoma

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: Recommended Combination Regimens

Tumor Histology	Patient Weight	Imfinzi Dosage	Tremelimumab-actl Dosage	Platinum-based Chemotherapy Regimen
Non-Squamous	≥ 30 kg	1,500 mg	75 mg	carboplatin & nab-paclitaxel OR carboplatin or cisplatin & pemetrexed
	< 30 kg	20 mg/kg	1 mg/kg	
Squamous	≥ 30 kg	1,500 mg	75 mg	carboplatin & nab-paclitaxel OR carboplatin or cisplatin & gemcitabine
	< 30 kg	20 mg/kg	1 mg/kg	

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
NSCLC	• Weight < 30 kg: 1 mg/kg IV every 3 weeks in combination with durvalumab 20 mg/kg and platinum-based chemotherapy for 4 cycles, and then durvalumab 20 mg/kg every 4 weeks as a single agent with histology-based pemetrexed therapy every 4 weeks, and a fifth dose of Imjudo 1mg/kg in combination with durvalumab dose 6 at week 16 • Weight ≥30 kg: 75 mg IV every 3 weeks in combination with durvalumab 1,500 mg and platinum-based chemotherapy for 4 cycles, and then durvalumab 1,500 mg every 4 weeks as a single agent with histology-based pemetrexed therapy every 4 weeks, and a fifth dose of Imjudo 75 mg in combination with durvalumab dose 6 at week 16	See regimen
uHCC	• Weight < 30 kg: 4 mg/kg IV as a single dose in combination with durvalumab 20 mg/kg at Cycle 1/Day 1, followed by durvalumab as a single agent every 4 weeks • Weight ≥30 kg: 300 mg IV as a single dose in combination with durvalumab 1,500 mg at Cycle 1/Day 1, followed by durvalumab as a single agent every 4 weeks	See regimen

VI. Product Availability

Single-dose vials: 25 mg/1.25 mL, 300 mg/15 mL

VII. References

1. Imjudo Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; July 2024. Available at: https://www.imfinzihcp.com. Accessed October 22, 2024.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at https://www.nccn.org/professionals/drug_compendium/content/. Accessed October 22, 2024.
3. National Comprehensive Cancer Network. Non-Small Cell Lung Cancer Version 11.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed October 22, 2024.
4. National Comprehensive Cancer Network. Hepatocellular Carcinoma Version 3.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/hcc.pdf. Accessed October 22, 2024.
5. National Comprehensive Cancer Network. Gastric Cancer Version 4.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/gastric.pdf. Accessed October 22, 2024.
6. National Comprehensive Cancer Network. Esophageal and Esophagogastric Junction Cancers Version 4.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/esophageal.pdf. Accessed October 22, 2024.

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
J9347	Injection, tremelimumab-actl, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	12.02.22	02.23
Added updated HCPCS code [J9347]	05.24.23	
1Q 2024 annual review: in initial approval criteria, added section C to include gastric, esophageal and esophagogastric junction cancer for off-label NCCN recommended uses per NCCN compendium; removed inactive HCPCS codes; references reviewed and updated	11.15.23	02.24
For uHCC, revised continued therapy section to not permit re-authorization per package insert	07.25.24	
1Q 2025 annual review: per NCCN compendium– for NSCLC, added recommended uses for present and negative actionable molecular biomarkers; revised NCCN recommended uses section to Gastric, Esophageal, and Esophagogastric Junction Cancer, added	10.23.24	02.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
requirement that disease is MSI-H or dMMR, and added provider attestation that member is medically fit for surgery; clarified prior authorization may be required for durvalumab; revised Commercial continued approval duration from 12 months to standard duration for injectables, 6 months or to the member's renewal date, whichever is longer; references reviewed and updated.		

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.