Geisinger

POLICIES AND PROCEDURE MANUAL

Policy: MBP 270.0

Section: Medical Benefit Pharmaceutical Policy

Subject: Imjudo (tremelimumab-actl)

Applicable line of business:

Commercial	X	Medicaid	X
Medicare	X	ACA	X
CHIP	X		

I. Policy:
Imjudo (tremelimumab-actl)

II. Purpose/Objective:
To provide a policy of coverage regarding Imjudo (tremelimumab-actl)

III. Responsibility:
A. Medical Directors
B. Medical Management
C. Pharmacy Department

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:
a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards good medical treatment practiced by the general medical community;
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient

Medicaid Business Segment
Medically Necessary — A service, item, procedure, or level of care compensable under the Medical Assistance program that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

i. Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
ii. Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
iii. Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

DESCRIPTION:
Imjudo (tremelimumab-actl) is a cytotoxic T-lymphocyte-associated antigen 4 (CTLA-4) blocking human IgG2 monoclonal antibody. CTLA-4 is a negative regulator of T-cell activity. Tremelimumab binds to CTLA-4 and blocks interaction with its ligands CD80 and CD86, releasing CTLA-4-mediated inhibition of T-cell activation. In animal tumor models, blocking CTLA-4 activity resulted in decreased tumor growth and increased proliferation of T-cells in tumors.

CRITERIA FOR USE: Requires Prior Authorization by Medical Director or Designee

GRANDFATHER PROVISION – Members already established on therapy are eligible for approval as long as there is medical record documentation that the safety and effectiveness of use for the prescribed indication is supported by Food and Drug Administration (FDA) approval or adequate medical and scientific evidence in the medical literature

Imjudo (tremelimumab-actl) will be considered medically necessary for all lines of business when ALL of the following criteria are met:

1. Unresectable Hepatocellular Carcinoma (uHCC)
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that Imjudo is prescribed by a hematologist or oncologist **AND**
- Medical record documentation of unresectable hepatocellular carcinoma (uHCC) **AND**
- Medical record documentation that Imjudo will be used in combination with durvalumab (Imfinzi)

AUTHORIZATION DURATION (uHCC): Approval will be given for a one-time dose of Imjudo (not to exceed 300 mg) for a duration of 1 month. Authorization of Imjudo for the treatment of unresectable HCC should not exceed the FDA-approved treatment of one dose. For requests exceeding the above limit, medical record documentation of the following is required:
- Peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration

2. Metastatic Non-Small Cell Lung Cancer (NSCLC)
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that Imjudo is prescribed by a hematologist or oncologist **AND**
- Medical record documentation of metastatic non-small cell lung cancer (NSCLC) **AND**
- Medical record documentation no sensitizing epidermal growth factor receptor (EGFR) mutation or anaplastic lymphoma kinase (ALK) genomic tumor aberrations **AND**
- Medical record documentation that Imjudo will be used in combination with durvalumab (Imfinzi) and platinum-based chemotherapy

AUTHORIZATION DURATION (Metastatic NSCLC): Initial approval will be for 6 months. Authorization of Imjudo for the treatment of metastatic NSCLC should not exceed the FDA-approved treatment duration of 16 weeks. For requests exceeding the above limit, medical record documentation of the following is required:
- Peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration

Note: For Medicaid (GHP Family), any requests for services that do not meet criteria set in the PARP will be evaluated on a case-by-case basis.

LINE OF BUSINESS:
Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy.

REFERENCES:

1. Imjudo [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; June 2023.

This policy will be revised as necessary and reviewed no less than annually.

Devised: 1/17/23

Revised: 12/28/23 (references added), 1/8/25 (LOB table, taglines)

Reviewed: 1/9/24

MA UM Committee approval: 12/31/23, 12/31/24, 4/29/25