Geisinger

POLICIES AND PROCEDURE MANUAL

Policy: MBP 309.0

Section: Medical Benefit Pharmaceutical Policy

Subject: Bevacizumab (Avastin) and Biosimilars

I. Policy:
Bevacizumab (Avastin) and Biosimilars

II. Purpose/Objective:
To provide a policy of coverage regarding Avastin (bevacizumab), Alymsys (bevacizumab-maly), Mvasi (bevacizumab-awwb), Vegzelma (bevacizumab-adcd), Zirabev (bevacizumab-bvzr).

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
3. the department requiring/authoring the policy.
4. Devised – the date the policy was implemented.
5. Revised – the date of every revision to the policy, including typographical and grammatical changes.
6. 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:
Bevacizumab is a recombinant, humanized monoclonal antibody which binds to, and neutralizes, vascular endothelial growth factor (VEGF), preventing its association with endothelial receptors, Flt-1 and KDR. VEGF binding initiates angiogenesis (endothelial proliferation and the formation of new blood vessels). The inhibition of microvascular growth is believed to slow the growth of all tissues (including metastatic tissue).

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

For commercial, exchange, CHIP, and Medicaid lines of business, Alymsys (bevacizumab-maly), Mvasi (bevacizumab-awwb), Vegzelma (bevacizumab-adcd), and Zirabev (bevacizumab-bvzr) do not require prior authorization.

Avastin (bevacizumab) used for intravitreal injection does NOT require prior authorization. Otherwise, Avastin (bevacizumab) will be considered medically necessary when ALL of the following criteria are met:

- Medical record documentation of a therapeutic failure of, intolerance to, or contraindication to **all** of the following: Alymsys (bevacizumab-maly), Mvasi (bevacizumab-awwb), Vegzelma (bevacizumab-adcd), Zirabev (bevacizumab-bvzr).

AUTHORIZATION DURATION:
For adjuvant treatment of Stage III or IV Epithelial Ovarian, Fallopian Tube or Primary Peritoneal Cancer following initial surgical resection:
Authorization will be for one (1) 21 month approval. Authorization of Avastin for adjuvant treatment should not exceed the FDA-approved treatment duration of 21 months (28 cycles). 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

For all other indications:
Authorization will be open-ended

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.

For the Medicare line of business, Alymsys (bevacizumab-maly), Mvasi (bevacizumab-awwb), Vegzelma (bevacizumab-adcd), and Zirabev (bevacizumab-bvzr) do not require prior authorization.

Avastin (bevacizumab) used for intravitreal injection does NOT require prior authorization. Otherwise, Avastin (bevacizumab) will be considered medically necessary when ALL of the following criteria are met:

- Medical record documentation of a therapeutic failure of, intolerance to, or contraindication to two (2) of the following: Alymsys (bevacizumab-maly), Mvasi (bevacizumab-awwb), Vegzelma (bevacizumab-adcd), Zirabev (bevacizumab-bvzr).

AUTHORIZATION DURATION:
For adjuvant treatment of Stage III or IV Epithelial Ovarian, Fallopian Tube or Primary Peritoneal Cancer following initial surgical resection:
Authorization will be for one (1) 21 month approval. Authorization of Avastin for adjuvant treatment should not exceed the FDA-approved treatment duration of 21 months (28 cycles). 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

For all other indications:
Authorization will be open-ended

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. Zirabev [prescribing information]. New York, NY. Pfizer, Inc.; February 2021.
2. Alymsys [prescribing information]. Bridgewater, NJ. Amneal Pharmaceuticals LLC; April 2022.
3. Vegzelma [prescribing information]. Incheon, Republic of Korea. Celltrion, Inc.; September 2022.
4. Zirabev [summary review]. New York, NY. Pfizer, Inc.; February 2021.
5. Alymsys [multi-discipline review]. Bridgewater, NJ. Amneal Pharmaceuticals LLC; April 2022.
6. Vegzelma [multi-discipline review]. Incheon, Republic of Korea. Celltrion, Inc.; September 2022.

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

Devised: 1/16/24

Revised:

Reviewed:

MA UM Committee approval: 5/22/24