

## Clinical Policy: Polatuzumab Vedotin-piiq (Polivy)

Reference Number: LA.PHAR.433

Effective Date:

Last Review Date: 01.21

Line of Business: Medicaid

[Coding  
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Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

Polatuzumab vedotin-piiq (Polivy™) is a CD79b-directed antibody-drug conjugate with activity against dividing B cells.

### FDA Approved Indication(s)

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.

### Policy/Criteria

Prior authorization is required. 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 Louisiana Healthcare Connections that Polivy is medically necessary when the following criteria are met:

#### I. Initial Approval Criteria

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

1. Diagnosis of DLBCL (see subtypes at Appendix D);
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. Member has received ≥ 2 prior therapies (see Appendix B);
6. Polivy is prescribed in combination with bendamustine\* and a rituximab product\* (see Appendix B for rituximab products);  
*\*Prior authorization may be required for bendamustine and rituximab products*
7. 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.*

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**Approval duration: 6 months (medical justification supports requests for cycles beyond 6)**

#### **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 (see Appendix B);**
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: 6 months (medical justification is required for requests for more than 6 cycles)**

#### **C. Other diagnoses/indications**

1. **Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): LA.PMN.53 for Medicaid.**

## **II. Continued Therapy**

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

1. **Currently receiving medication via Louisiana Healthcare Connections benefit, 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 meets one of the following (a or b):**

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- a. Member has received < 6 cycles of Polivy;
- b. Member has received < the number of cycles recommended by NCCN for the covered indication;
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: 12 months (medical justification supports requests for cycles beyond 6)

#### B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Louisiana Healthcare Connections benefit and documentation supports positive response to therapy.  
Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): LA.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 policy – LA.PMN.53 for Medicaid.

#### IV. Appendices/General Information

##### Appendix A: Abbreviation/Acronym Key

DLBCL: diffuse large B-cell lymphoma

FDA: Food and Drug Administration

FL: follicular lymphoma

HGBL: high-grade B-cell lymphoma

NCCN: National Comprehensive Cancer Network

NOS: not otherwise specified

##### Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may require prior authorization.

<u>Drug Name</u>	<u>Dosing Regimen</u>	<u>Dose Limit/ Maximum Dose</u>
<u>Rituximab Products</u>		
<u>Rituxan<sup>®</sup> (rituximab), Truxima<sup>®</sup> (rituximab-abbs), Rituxan Hycela<sup>®</sup> (rituximab-hyaluronidase)</u>	<u>Varies</u>	<u>Varies</u>
<u>DLBCL Regimen examples (NCCN)</u>		
<u>bendamustine ± rituximab</u>	<u>Varies</u>	<u>Varies</u>
<u>CEPP (cyclophosphamide, etoposide, prednisone, procarbazine) ± rituximab</u>	<u>Varies</u>	<u>Varies</u>
<u>lenalidomide ± rituximab</u>	<u>Varies</u>	<u>Varies</u>

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<u>Drug Name</u>	<u>Dosing Regimen</u>	<u>Dose Limit/ Maximum Dose</u>
<b><u>HGBL Regimen examples (NCCN)</u></b>		
<b><u>DA-EPOCH-R (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin + rituximab)</u></b>	<b><u>Varies</u></b>	<b><u>Varies</u></b>
<b><u>RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone)</u></b>	<b><u>Varies</u></b>	<b><u>Varies</u></b>
<b><u>FL (grade 1-2) Regimen examples (NCCN)</u></b>		
<b><u>Anthracycline- or anthracenedione-based regimens: CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) + obinutuzumab or rituximab</u></b> <b><u>CVP (cyclophosphamide, vincristine, prednisone) + obinutuzumab or rituximab</u></b>	<b><u>Varies</u></b>	<b><u>Varies</u></b>
<b><u>RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone)</u></b>	<b><u>Varies</u></b>	<b><u>Varies</u></b>
<b><u>Mantle Cell Lymphoma Regimen examples (NCCN)</u></b>		
<b><u>RDHA (rituximab, dexamethasone, cytarabine) + platinum (carboplatin, cisplatin, or oxaliplatin)</u></b>	<b><u>Varies</u></b>	<b><u>Varies</u></b>
<b><u>VR-CAP (bortezomib, rituximab, cyclophosphamide, doxorubicin, and prednisone)</u></b>	<b><u>Varies</u></b>	<b><u>Varies</u></b>
<b><u>Post-Transplant Lymphoproliferative Disorder Regimen examples (NCCN)</u></b>		
<b><u>CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) + obinutuzumab or rituximab</u></b>	<b><u>Varies</u></b>	<b><u>Varies</u></b>
<b><u>CVP (cyclophosphamide, vincristine, prednisone) + obinutuzumab or rituximab</u></b>	<b><u>Varies</u></b>	<b><u>Varies</u></b>
<b><u>AIDS-related B-Cell Lymphoma Regimen examples (NCCN)</u></b>		
<b><u>R-EPOCH (rituximab, etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin)</u></b>	<b><u>Varies</u></b>	<b><u>Varies</u></b>
<b><u>CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) + rituximab</u></b>	<b><u>Varies</u></b>	<b><u>Varies</u></b>
<b><u>Histologic Transformation of Nodal Marginal Zone Lymphoma to DLBCL Regimen examples (NCCN)</u></b>		
<b><u>RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone)</u></b>	<b><u>Varies</u></b>	<b><u>Varies</u></b>

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

#### Appendix C: Contraindications/Boxed Warnings

**None reported**

#### Appendix D: DLBCL Subtypes per the National Comprehensive Cancer Network (NCCN)

- **DLBCL, NOS (FDA-approved use)**
- **DLBCL coexistent with follicular lymphoma of any grade**
- **DLBCL coexistent with gastric MALT lymphoma**
- **DLBCL coexistent with nongastric MALT lymphoma**

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- Follicular lymphoma grade 3
- Intravascular large B-cell lymphoma
- DLBCL associated with chronic inflammation
- ALK-positive DLBCL
- EBV-positive DLBCL, NOS
- T-cell/histiocyte-rich large B-cell lymphoma
- DLBCL with IRF4/MUM1 rearrangement

### V. Dosage and Administration

<u>Indication</u>	<u>Dosing Regimen</u>	<u>Maximum Dose</u>
<u>DLBCL</u>	<p><u>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.)</u></p> <ul style="list-style-type: none"> <li>• <u>Bendamustine: The recommended dose of bendamustine is 90 mg/m<sup>2</sup>/day IV on Day 1 and 2 when administered with Polivy and a rituximab product.</u></li> <li>• <u>Rituximab product: The recommended dose of rituximab product is 375 mg/m<sup>2</sup> IV on Day 1 of each cycle.</u></li> </ul>	<u>1.8 mg/kg (Polivy)</u>

### VI. Product Availability

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

### VII. References

1. Polivy Prescribing Information. South San Francisco, CA: Genentech, Inc.; September 2020. Available at: [https://www.gene.com/download/pdf/polivy\\_prescribing.pdf](https://www.gene.com/download/pdf/polivy_prescribing.pdf). Accessed November 30, 2020.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: [http://www.nccn.org/professionals/drug\\_compendium](http://www.nccn.org/professionals/drug_compendium). Accessed April 23, 2020.
3. National Comprehensive Cancer Network. B-Cell Lymphomas Version 1.2020. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/b-cell.pdf](https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf). Accessed April 23, 2020.

### 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.

<u>HCPCS Codes</u>	<u>Description</u>
<u>J9999</u>	<u>Injection, polatuzumab vedotin-piiq (Polivy)</u>

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<u>Reviews, Revisions, and Approvals</u>	<u>Date</u>
<u>Converted corporate to local policy</u>	<u>01.21</u>

#### 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. LHCC 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.

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