Clinical Policy: Ipilimumab (Yervoy)

Reference Number: LA.PHAR.319
Effective Date: 07.01.22
Last Review Date: 06.02.23~~04.22~~
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

****Please note: This policy is for medical benefit****

Description

Ipilimumab (Yervoy®) is a human cytotoxic T-lymphocyte antigen 4 (CTLA-4)-blocking antibody.

FDA Approved Indication(s)

Yervoy is indicated for:

- **Unresectable or metastatic melanoma**
  - Treatment of unresectable or metastatic melanoma in adults and pediatric patients 12 years and older as a single agent or in combination with nivolumab
  - ~~Treatment of unresectable or metastatic melanoma in combination with nivolumab in adult patients~~
- **Adjuvant treatment of melanoma**
  - Patients with cutaneous melanoma with pathologic involvement of regional lymph nodes of more than 1 mm who have undergone complete resection, including total lymphadenectomy
- **Renal cell carcinoma (RCC)**
  - Treatment of patients with intermediate or poor risk~~, previously untreated advance RCC, in combination with nivolumab~~ advance renal cell carcinoma, as first-line treatment in combination with nivolumab
- **Colorectal cancer (CRC)**
  - Treatment of adult and pediatric patients 12 years of age and older with microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) metastatic CRC that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan, in combination with nivolumab*
- **Hepatocellular carcinoma (HCC)**
  - In combination with nivolumab, the treatment of patients with HCC who have been previously treated with sorafenib*
- **Non-small cell lung cancer (NSCLC)**
  - In combination with nivolumab, for the first-line treatment of adult patients with metastatic NSCLC whose tumors express programmed death-ligand 1 (PD-L1) ≥ 1% as determined by an FDA-approved test, with no epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberrations
  - In combination with nivolumab and 2 cycles of platinum-doublet chemotherapy, for the first-line treatment of adult patients with metastatic or recurrent NSCLC, with no EGFR or ALK genomic tumor aberrations

- **Malignant pleural mesothelioma**
  - Treatment of adult patients with unresectable malignant pleural mesothelioma, as first-line treatment in combination with nivolumab
- **Esophageal cancer**
  - Treatment of adult patients with unresectable advanced or metastatic esophageal squamous cell carcinoma (ESCC), as first line treatment in combination with nivolumab

*This indication is approved under accelerated approval based on tumor response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

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 Yervoy is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Melanoma (must meet all)**:**

1. Diagnosis of unresectable, metastatic, or lymph node positive melanoma;
2. Prescribed by or in consultation with an oncologist;
3. Age is one of the following (a or b):
   a. For unresectable or metastatic disease: ≥ 12 years;
   b. For adjuvant treatment: ≥ 18 years;

~~3. Age ≥ 12 years;~~

4. Prescribed in one of the following ways (a or b):
   a. As a single agent;
   b. In combination with Opdivo®* for unresectable or metastatic melanoma~~,~~
   ~~b.~~ In combination with Keytruda®*~~,~~ for unresectable or metastatic melanoma or ~~Imlygic® and both of the following (i or ii):~~
   c.
   ~~Member has unresectable or metastatic melanoma~~
   ~~Age ≥ 18 years~~
   **Prior authorization may be required for Opdivo and~~,~~ Keytruda~~, and Imlygic~~*
5. Request meets one of the following (a, b, or c):*
   a. Unresectable or metastatic disease: Dose does not exceed 3 mg per kg every 3 weeks for a maximum of 4 doses;
   b. Adjuvant treatment: Dose does not exceed 10 mg/kg every 3 weeks for 4 doses, followed by 10 mg/kg every 12 weeks for up to 3 years;
   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. Renal Cell Carcinoma (must meet all)**:**

1. Diagnosis of advanced or metastatic RCC;

2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 12 years;
4. Prescribed in combination with Opdivo;*
   **Prior authorization may be required for Opdivo*
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 1 mg/kg IV every 3 weeks for a maximum of 4 doses;
   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: 16 weeks (maximum of 4 doses)

C. Colorectal Cancer (must meet all)**:**
1. Diagnosis of MSI-H or dMMR CRC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 12 years;
4. Disease is unresectable or metastatic;
5. Prescribed in combination with Opdivo;
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 1 mg/kg IV every 3 weeks for a maximum of 4 doses;
   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: 16 weeks (maximum of 4 doses)

D. Hepatocellular Carcinoma (must meet all):
1. Diagnosis of HCC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Member has previously received Nexavar®, Lenvima®, or Tecentriq® + bevacizumab
   **Prior authorization may be required for Nexavar, Lenvima, Tecentriq, bevacizumab, and Imfinzi*
5. Prescribed in combination with Opdivo;
   **Prior authorization may be required for Opdivo*
6. Documentation of Child-Pugh Class A status;
~~7. Member has not had previous treatment with a checkpoint inhibitor (e.g., Opdivo, Keytruda®, Tecentriq®, Imfinzi®);~~
~~8.~~7. Request meets one of the following (a or b):*
   a. Dose does not exceed 3 mg/kg IV every 3 weeks for a maximum of 4 doses;
   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: 16 weeks (maximum of 4 doses)

E. 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 Opdivo;*

**Prior authorization may be required for Opdivo*

5. Member has not previously progressed on a PD-1/PD-L1 inhibitor therapy (e.g., Opdivo, Keytruda, Tecentriq, Imfinzi) (*see Appendix D*);
6. Request meets one of the following (a, b, c, ~~or~~ d, e, or f):
   a. Disease mutation status is negative for actionable biomarkers (EGFR, KRAS, ALK, ROS1, BRAF, NTRK1/2/3, MET, ~~and~~ RET, AND ERBB2 [HER2]), and member has not received prior systemic therapy for advanced disease;
   b. Disease mutation status is positive for EGFR S768I, L861Q, and/or G719X, and member has received prior afatinib, osimertinib, erlotinib, gefitinib, or dacomitinib;*
   c. Disease mutation status is positive for EGFR exon 19 deletion or L858R, and member has received prior erlotinib ± (ramucirumab or bevacizumab), afatinib, gefitinib, osimertinib, or dacomitinib;*
   d. Disease mutation status is positive for ROS1 rearrangement, and member has received prior crizotinib, entrectinib, or ceritinib;*
   ~~c.~~e. Disease mutation status is positive for ALK rearrangement, and member has received prior crizotinib, ceritinib, alectinib, brigatinib, or lorlatinib;*
   ~~d.~~f. Disease mutation status is positive for EGFR exon 20, KRAS G12C, NRTK1/2/3, BRAF V600E, MET exon 14 skipping, RET rearrangement, or ERBB2 (HER2);
   **Prior authorization may be required*
7. Request meets one of the following (a or b):*
   a. Dose does not exceed 1 mg/kg IV every 6 weeks in combination with Opdivo;
   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

F. Malignant Pleural Mesothelioma (must meet all)**:**

1. Diagnosis of unresectable malignant pleural mesothelioma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed in combination with Opdivo;*
   **Prior authorization may be required for Opdivo.*
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 1 mg/kg IV every 6 weeks in combination with Opdivo;
   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

G. Esophageal Cancer (must meet all)**:**

1. Diagnosis of unresectable advanced or metastatic ESCC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed in combination with Opdivo;*
   **Prior authorization may be required for Opdivo.*
5. Request meets one of the following (a or b):*

a. Dose does not exceed 1 mg/kg IV every 6 weeks in combination with Opdivo;
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

~~G.~~**H. NCCN Compendium Indications (off-label)** (must meet all)**:**

1. Diagnosis of one of the following (a ~~-for b~~):
   a. MSI-H or dMMR small bowel adenocarcinoma;
   b. Metastatic uveal melanoma;
   c. MSI-H or dMMR ampullary adenocarcinoma;
   d. Bone cancer (e.g., chondrosarcoma, osteosarcoma, chordoma, Ewing sarcoma), and both of the following (i and ii):
      i. Disease is unresectable or metastatic with tissue tumor mutation burden-high tumors with 10 or more mutations per megabase;
      ii. Disease has progressed following prior treatment and no satisfactory alternative treatment options exist;
   e. BRAF non-specific melanoma brain metastases;
   ~~b.~~f. Classic Kaposi sarcoma as subsequent systemic therapy;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 12 years;
4. Prescribed in combination with Opdivo for all of the following (a-d):*
   a. MSI-H/dMMR small bowel adenocarcinoma;
   b. MSI-H/dMMR ampullary adenocarcinoma;
   c. Bone cancer;
   d. Classic Kaposi sarcoma;

~~4. For MSI-H/dMMR small bowel adenocarcinoma:Prescribed in combination with Opdivo~~

5. For uveal melanoma: Prescribed as a single agent or in combination with Opdivo;*
   **Prior authorization may be required for Opdivo*
6. 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

I. 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 LA.PMN.255
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 LA.PMN.53

~~**H. 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. Melanoma - Unresectable or Metastatic

1. Reauthorization beyond 16 weeks is not permitted. Members must meet the initial approval criteria, at a minimum of 3 months since initial treatment discontinuation.

Approval duration: Not applicable

B. Renal Cell Carcinoma, Colorectal Cancer, Hepatocellular Carcinoma

1. Reauthorization beyond 16 weeks is not permitted. Members must meet the initial approval criteria.

Approval duration: Not applicable

C. Melanoma (Adjuvant Treatment), Non-Small Cell Lung Cancer, Malignant Pleural Mesothelioma, Esophageal Cancer (must meet all)**:**

1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Yervoy 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 one of the following (a, b, or c):*
   a. For melanoma: New dose does not exceed 10 mg/kg every 12 weeks for up to 3 years;
   b. For NSCLC, malignant pleural mesothelioma, and ESCC: New dose does not exceed 1 mg/kg IV every 6 weeks in combination with Opdivo;
   c. 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 or up to a total duration of 3 years (cutaneous melanoma) or 2 years (NSCLC, malignant pleural mesothelioma, ESCC), whichever is less

D. NCCN Compendium Indications (off-label) (must meet all)**:**

1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Yervoy for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. 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: 12 months

E. 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 LA.PMN.255

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 LA.PMN.53

~~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, or evidence of coverage documents.~~

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALK: anaplastic lymphoma kinase
BRAF: B-Raf proto-oncogene, serine/ threonine kinase
CRC: colorectal cancer
CTLA-4: cytotoxic T-lymphocyte antigen 4
dMMR: mismatch repair deficient
EGFR: epidermal growth factor receptor
FDA: Food and Drug Administration
HCC: hepatocellular carcinoma
MET: mesenchymal-epithelial transition
MSI-H: microsatellite instability-high
PD-1: programmed death-1
PD-L1: programmed death-ligand 1
RCC: renal cell carcinoma
ROS1: ROS proto-oncogene 1

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Opdivo (nivolumab)	**MSI-H/dMMR small bowel adenocarcinoma** 3 mg/kg IV once every 3 weeks for four doses, then 3 mg/kg IV or 240 mg IV every 2 weeks with or without ipilimumab **Unresectable or metastatic melanoma** Adult and pediatric weighing ≥ 40 kg: nivolumab 1 mg/kg every 3 weeks for four doses in combination with ipilimumab 3 mg/kg every 3 weeks, then nivolumab 240 mg every 2 weeks or 480 mg every 4 weeks as a single agent until disease progression or unacceptable toxicity	RCC, HCC, melanoma: 480 mg/dose CRC, small bowel adenocarcinoma, pediatric (weighing < 40 kg) melanoma: 240 mg/dose

	Pediatric weighing < 40 kg: nivolumab 1 mg/kg every 3 weeks for four doses in combination with ipilimumab 3 mg/kg every 3 weeks, then nivolumab 3 mg/kg every 3 weeks or 6 mg/kg mg every 6 weeks as a single agent until disease progression or unacceptable toxicity	
Keytruda (pembrolizumab)	**Melanoma** Adult: 200 mg every 3 weeks or 400 mg every 6 weeks Pediatric: 2 mg/kg (up to 200 mg) every 3 weeks	See regimen
Nexavar (sorafenib)	**HCC** 400 mg PO BID	800 mg/day
Lenvima (lenvatinib)	**HCC** 12 mg PO QD (patients ≥ 60 kg) or 8 mg PO QD (patients < 60 kg)	12 mg/day
Tecentriq (atezolizumab) + bevacizumab (Avastin®, Mvasi, Zirabev)	**HCC** Tecentriq: 840 mg IV every 2 weeks, 1,200 mg IV every 3 weeks, or 1,680 mg IV every 4 weeks Bevacizumab: 15 mg/kg IV every 3 weeks	See regimen
Imfinzi (durvalumab)*	**HCC** Varies	Varies
platinum-containing regimens	**NSCLC – squamous cell carcinoma** paclitaxel + carboplatin dose varies **NSCLC – nonsquamous cell carcinoma** pemetrexed + [carboplatin or cisplatin] dose varies	Varies
EGFR S768I, L861Q, and/or G719X targeted therapies: afatinib, osimertinib, erlotinib, gefitinib, dacomitinib	**NSCLC** Varies	Varies
ROS1 targeted therapies: crizotinib, entrectinib, ceritinib	**NSCLC** 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.
**Off-label*

Appendix C: Contraindications and Boxed Warnings

- Bristol-Myers Squibb was released from the REMS program for Yervoy in March 2015.
- Boxed warning(s): none reported
- Contraindication(s): none reported

Appendix D: General Information

- NCCN no longer recommends the use of Yervoy for the following indications~~small cell lung cancer or tumor mutation burden NSCLC~~
  - Small cell lung cancer
  - Tumor mutation burden NSCLC
  - Cutaneous melanoma, as adjuvant systemic therapy in combination with Opdivo if no evidence of disease following metastasis-directed therapy or systemic therapy for oligometastatic disease
  - Colon cancer for patients who are not appropriate for intensive therapy
- Per NCCN, contraindications for treatment with PD-1/PD-L1 inhibitors may include active or previously documented autoimmune disease and/or current use of immunosuppressive agents, or presence of an oncogene (i.e., EGFR exon 19 deletion or L858R, ALK rearrangements), which would predict lack of benefit.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Melanoma (adjuvant treatment)	10 mg/kg IV every 3 weeks for 4 doses, followed by 10 mg/kg every 12 weeks for up to 3 years or until documented disease recurrence or unacceptable toxicity.	10 mg/kg/dose
Melanoma (unresectable or metastatic)	Monotherapy: 3 mg/kg IV every 3 weeks for a total of 4 doses In combination with nivolumab: 3 mg/kg every 3 weeks with nivolumab 1 mg/kg for a maximum of 4 doses or until unacceptable toxicity, whichever occurs earlier.	3 mg/kg/dose
RCC	Nivolumab 3 mg/kg IV, followed by ipilimumab 1 mg/kg IV on the same day, every 3 weeks for a maximum of 4 doses, then nivolumab 240 mg IV every 2 weeks or 480 mg IV every 4 weeks	1 mg/kg/dose
CRC	Nivolumab 3 mg/kg IV, followed by ipilimumab 1 mg/kg IV on the same day, every 3 weeks for a maximum of 4 doses or until intolerable toxicity or disease progression, then nivolumab 240 mg IV every 2 weeks or 480 mg IV every 4 weeks	1 mg/kg/dose

Indication	Dosing Regimen	Maximum Dose
HCC	Nivolumab 1 mg/kg IV, followed by ipilimumab 3 mg/kg IV on the same day, every 3 weeks for a maximum of 4 doses, then nivolumab 240 mg IV every 2 weeks or 480 mg IV every 4 weeks	3 mg/kg/dose
NSCLC	In combination with nivolumab: nivolumab 3 mg/kg IV every 2 weeks and ipilimumab 1 mg/kg IV every 6 weeks until disease progression, unacceptable toxicity, or for up to 2 years in patients without disease progression In combination with nivolumab and platinum-doublet chemotherapy: nivolumab 360 mg IV every 3 weeks and ipilimumab 1 mg/kg IV every 6 weeks and histology-based platinum-doublet chemotherapy every 3 weeks for 2 cycles until disease progression, unacceptable toxicity, or up to 2 years in patients without disease progression	1 mg/kg/dose
Malignant pleural mesothelioma	1 mg/kg every 6 weeks with nivolumab 360 mg every 3 weeks until disease progression, unacceptable toxicity, or up to 2 years in patients without disease progression.	1 mg/kg/dose
ESCC	1 mg/kg every 6 weeks with nivolumab 3 mg/kg every 2 weeks or 360 mg every 3 weeks until disease progression, unacceptable toxicity, or up to 2 years in patients without disease progression.	1 mg/kg/dose

VI. Product Availability

Single-use vials: 50 mg/10 mL, 200 mg/40 mL

VII. References

1. Yervoy Prescribing information. Princeton, NJ: Bristol-Myers Squibb Company; Marchy 2023~~1~~. Available at: https://packageinserts.bms.com/pi/pi_yervoy.pdf. Accessed ~~January 28~~March 16, 2023~~2~~.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed ~~January 28, 2022~~April 12, 2023.
3. National Comprehensive Cancer Network. Malignant Pleural Mesothelioma Version 1.2023~~2~~. Available at: https://www.nccn.org/professionals/physician_gls/pdf/mpm.pdf. Accessed ~~January 28, 2022.~~February 7, 2023.
4. National Comprehensive Cancer Network. Non-Small Cell Lung Cancer Version 1.2023~~2~~. Available at: https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed February 7~~January 28~~, 2023~~2~~.

5. Hellman MD, Paz-Ares L, Bernabe Caro R, et al. Nivolumab plus ipilimumab in advanced non-small-cell lung cancer. N Engl J Med. 2019 November; 381(21):2020-2031.
6. National Comprehensive Cancer Network. Hepatobiliary Cancers, Version 5.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/hepatobiliary.pdf. Accessed February 7, 2023.
7. National Comprehensive Cancer Network. Esophageal and Esophagogastric Junction Cancers, Version 5.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/esophageal.pdf. Accessed February 7, 2023.
~~5.~~8. National Comprehensive Cancer Network. Melanoma:Cutaneous, Version 02.2023. Available at: www.nccn.org/professionals/physician_gls/pdf/cutaneous_melanoma.pdf. Accessed April 12, 2023.

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
J9228	Injection, ipilimumab, 1 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted corporate to local policy	04.22	07.01.22
Criteria added for new FDA approved indication of ESCC in combination with Opdivo; for HCC, added additional option for prior use of Imfinzi and removed requirement for no previous treatment with a checkpoint inhibitor per latest NCCN guidelines. For melanoma clarified combination use with Keytruda and removed combination use with Imlygic per NCCN 2B recommendation; updated FDA indication for RCC to mirror PI; revised NSCLC criteria to include additional requirements related to mutation status, added off-label use for MSI-H/dMMR ampullary adenocarcinoma, bone cancer, brain metastases, and Kaposi sarcoma per NCCN compendium; Updated criteria for melanoma to reflect FDA approved pediatric age extension for use in combination with Opdivo and updated appendix B. References reviewed and updated.	06.02.23	

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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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 LHCC has no control or right of control. Providers are not agents or employees of LHCC.