Clinical Policy: Enfortumab Vedotin-ejfv (Padcev)

Reference Number: LA.PHAR.455
Effective Date:
Last Review Date: ~~05.01.23~~07.20.23 Coding Implications
Line of Business: Medicaid 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
Enfortumab vedotin-ejfv (Padcev™) is a Nectin-4-directed antibody and microtubule inhibitor conjugate.

FDA Approved Indication(s)
Padcev is indicated:

- ~~F~~for the treatment of adult patients with locally advanced or metastatic urothelial cancer who:
  - ~~o~~ have previously received a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor, and a platinum-containing chemotherapy, or
  - o are ineligible for cisplatin-containing chemotherapy and have previously received one or more prior lines of therapy.
- In combination with pembrolizumab for the treatment of adult patients with locally advanced or metastatic urothelial cancer who are not eligible for cisplatin-containing chemotherapy.*

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

I. Initial Approval Criteria

A. Urothelial Carcinoma (must meet all)**:**

1. Diagnosis of recurrent, locally advanced, or metastatic (stage IV) urothelial carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;

4. Member meets one of the following (a or b):
   a. Failure of both of the following (i and ii):
      i. Platinum-containing chemotherapy (s*ee Appendix B*);
      ii. PD-1 or PD-L1 inhibitor (s*ee Appendix B*);
   b. Member is ineligible for cisplatin-containing chemotherapy and has previously received one or more prior lines of therapy (s*ee Appendix B*);
   ~~b.~~c. Member is ineligible for cisplatin-containing chemotherapy and will use Padcev in combination with pembrolizumab;
5. Request meets one of the following (a, ~~or~~ b, or c):*
   a. Dose does not exceed 1.25 mg/kg (up to 125 mg) on days 1, 8, and 15 of a 28-day cycle;
   b. If administered with pembrolizumab, dose does not exceed 1.25 mg/kg (up to 125 mg) on days 1 and 8 of a 21-day cycle;
   ~~a.~~
   ~~b.~~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. 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 for the relevant line of business: LA.PMN.53 for Medicaid.

II. Continued Therapy

A. Urothelial Carcinoma (must meet all)**:**

1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Padcev for a covered indication and has received this medication for at least 28 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 ~~or b~~):*
   a. New dose does not exceed 1.25 mg/kg (up to 125 mg) on days 1, 8 and 15 of a 28-day cycle;
   ~~a.~~b. If administered with pembrolizumab, dose does not exceed 1.25 mg/kg (up to 125 mg) on days 1 and 8 of a 21-day cycle;
   ~~b.~~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

B. 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 for the relevant line of business: 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 policies – LA.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
PD-1: programmed death receptor-1
PD-L1: programmed death-ligand
NCCN: National Comprehensive Cancer Network

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 for all relevant lines of business and may~~ require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Examples of platinum-containing regimens		
DDMVAC (dose-dense methotrexate, vinblastine, doxorubicin, and cisplatin)	Varies	Varies
gemcitabine with either cisplatin or carboplatin	Varies	Varies
Examples of PD-1 inhibitors		
Keytruda® (pembrolizumab)	Varies	Varies
Opdivo® (nivolumab)	Varies	Varies
Examples of PD-L1 inhibitors		
Tecentriq® (atezolizumab)	Varies	Varies
Imfinzi® (durvalumab)	10 mg/kg IV infusion every 2 weeks	Varies
Bavencio® (avelumab)	800 mg IV infusion once every 2 weeks	Varies
Other recommended regimens		
gemcitabine	Varies	Varies
gemcitabine and paclitaxel	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
ifosfamide, doxorubicin, gemcitabine	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.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): serious skin reactions

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Urothelial cancer	1.25 mg/kg (up to a maximum dose of 125 mg) given as an IV infusion over 30 minutes on Days 1, 8 and 15 of a 28-day cycle until disease progression or unacceptable toxicity. OR In combination with pembrolizumab, 1.25 mg/kg (up to a maximum dose of 125 mg) given as an intravenous infusion over 30 minutes on Days 1 and 8 of a 21-day cycle until disease progression or unacceptable toxicity.	See dosing regimen

VI. Product Availability

Single-dose vial for injection: 20 mg, 30 mg

VII. References

1. Padcev Prescribing Information. Northbrook, IL: Astellas Pharma US, Inc; ~~October~~ April 2023~~2~~. Available at: https://www.padcev.com. Accessed ~~November~~ July 20~~15~~, 2023~~2~~.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed November 15, 2022.
3. National Comprehensive Cancer Network. Bladder Cancer Version 2.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/bladder.pdf. Accessed November 15, 2022.
4. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed November 15, 2022.

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
J9177	Injection, enfortumab vedotin-ejfv, 0.25 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Policy created.	05.01.23	
Added an additional approved indication for administration with pembrolizumab for members ineligible for cisplatin-containing chemotherapy. Added additional approved dosing regimen for Urothelial cancer. Reviewed and updated references.	07.20.23	

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.