

Clinical Policy: Durvalumab (Imfinzi)

Reference Number: LA.PHAR.339

Effective Date: 07.23.22

Last Review Date: ~~06.02.23~~05.07.24

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

Durvalumab (Imfinzi®) is a programmed death-ligand 1 (PD-L1) blocking antibody.

FDA Approved Indication(s)

Imfinzi is indicated:

- For the treatment of adult patients with unresectable, stage III non-small cell lung cancer (NSCLC) whose disease has not progressed following concurrent platinum-based chemotherapy and radiation therapy.
- In combination with tremelimumab-actl (Imjudo®) and platinum-based chemotherapy, for the treatment of adult patients with metastatic NSCLC with no sensitizing epidermal growth factor receptor (EGFR) mutations or anaplastic lymphoma kinase (ALK) genomic tumor aberrations.
- In combination with etoposide and either carboplatin or cisplatin as first-line treatment of adults patients with extensive-stage small cell lung cancer (ES-SCLC).
- In combination with gemcitabine and cisplatin, as treatment of adult patients with locally advanced or metastatic biliary tract cancer (BTC).
- In combination with tremelimumab-actl (Imjudo®) for the treatment of adults patients with unresectable hepatocellular carcinoma (~~uHCC~~HCC).

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

I. Initial Approval Criteria**A. Non-Small Cell Lung Cancer** (must meet all):

1. Diagnosis of NSCLC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Request meets one of the following (a, b, or c):
 - a. Disease is unresectable, stage II-III, and has not progressed following concurrent platinum-based chemotherapy and radiation therapy (RT);

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- b. Disease is recurrent, advanced, or metastatic ~~with neither, and Imfinzi is prescribed in combination with Imjudo and platinum-based chemotherapy as one of the following (i-xi):~~
- ~~b.i. First-line therapy for disease without~~ sensitizing EGFR mutations, ALK genomic tumor aberrations, or ~~negative for~~ other actionable molecular biomarkers (e.g., KRAS, ROS1, BRAF, NTRK1/2/3, MET, RET, ERBB2 (HER2)) ~~and is prescribed in combination with Imjudo (tremelimumab-aetl) and platinum-based chemotherapy as first-line therapy (-) – note: may be KRAS G12C mutation positive) (see Appendix E);~~
- ~~ii. First-line therapy for EGFR exon 20 mutation positive disease;~~
- ~~iii. First-line or subsequent therapy for BRAF V600E mutation positive tumors;~~
- ~~iv. First-line or subsequent therapy for NTRK1/2/3 gene fusion positive tumors;~~
- ~~v. First-line or subsequent therapy for MET exon 14 skipping mutation positive tumors;~~
- ~~vi. First-line or subsequent therapy for RET rearrangement positive tumors;~~
- ~~vii. First-line therapy for ERBB2 (HER2) mutation positive tumors;~~
- ~~viii. Subsequent therapy for EGFR exon 19 deletion or exon 21 deletion or exon 21 L858R tumors and prior erlotinib ± (ramucirumab or bevacizumab), afatinib, gefitinib, osimertinib, or dacomitinib therapy;~~
- ~~ix. Subsequent therapy for EGFR S768I, L861Q, and/or G719X mutation positive tumors and prior afatinib, osimertinib, erlotinib, gefitinib, or dacomitinib therapy;~~
- ~~x. Subsequent therapy for ALK rearrangement positive tumors and prior crizotinib, ceritinib, alectinib, brigatinib, or lorlatinib therapy;~~
- ~~xi. Subsequent therapy for ROS1 rearrangement positive tumors and prior crizotinib, entrectinib, repotrectinib, or ceritinib therapy;~~
- c. Continuation maintenance therapy for recurrent, advanced, or metastatic disease that is negative for actionable molecular biomarkers (~~may be KRAS G12C mutation positive~~), and no contraindications to PD-1 or PD-L1 inhibitors (see *Appendix D*) and performance status 0-2, that achieved tumor response or stable disease following initial systemic therapy with one of the following (i or ii):
- i. Imfinzi/Imjudo/pemetrexed with either carboplatin or cisplatin for nonsquamous cell histology, and Imfinzi for maintenance therapy is prescribed in combination with pemetrexed (off-label);
- ii. Imfinzi/Imjudo plus chemotherapy, and Imfinzi for maintenance therapy is prescribed a single agent (off-label);
5. For brand Imfinzi requests, member must use generic durvalumab, if available, unless contraindicated or clinically significant adverse effects are experienced;
- 5.6. Request meets one of the following (a, b, or c):*
- a. For unresectable, stage II-III disease (i or ii):
- i. For body weight < 30 kg: ~~dose~~Dose does not exceed 10 mg/kg every 2 weeks;
- ii. For body weight ≥ 30 kg: ~~dose~~Dose does not exceed 10 mg/kg every 2 weeks or 1,500 mg every 4 weeks;
- b. For metastatic disease (i or ii):

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- i. For body weight < 30 kg: ~~dose~~Dose does not exceed Imfinzi 20 mg/kg every 3 weeks in combination with ~~tremelimumab-aetd~~Imjudo 1 mg/kg and platinum-based chemotherapy, and then Imfinzi 20 mg/kg every 4 weeks as a single agent with histology-based pemetrexed therapy every 4 weeks, and a fifth dose of Imjudo 1 mg/kg in combination with Imfinzi dose 6 at Week 16;
- ii. For body weight ≥ 30 kg: ~~dose~~Dose does not exceed Imfinzi 1,500 mg every 3 weeks in combination with ~~tremelimumab-aetd~~Imjudo 75 mg and platinum-based chemotherapy for 4 cycles, and then Imfinzi 1,500 mg every 4 weeks as a single agent with histology-based pemetrexed maintenance therapy every 4 weeks, and a fifth dose of Imjudo 75 mg in combination with Imfinzi dose 6 at Week 16;
- 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. Extensive-Stage Small Cell Lung Cancer (must meet all):

1. Diagnosis of ES-SCLC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
- 3-4. Prescribed as first-line treatment with etoposide and either carboplatin or cisplatin, followed by maintenance with Imfinzi as a single agent;
5. For brand Imfinzi requests, member must use generic durvalumab, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Request meets one of the following (a, b, or c):*
4. Request meets one of the following (a, b, or c):*
 - a. For body weight < 30 kg: ~~dose~~Dose does not exceed 20 mg/kg every 3 weeks in combination with chemotherapy for 4 cycles, then 10 mg/kg every 2 weeks as a single agent;
 - b. For body weight ≥ 30 kg: ~~dose~~Dose does not exceed 1,500 mg every 3 weeks in combination with chemotherapy for 4 cycles, then 1,500 mg every 4 weeks as a single agent;
 - 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

C. Biliary Tract Cancer (must meet all):

1. Diagnosis of locally advanced, unresectable, resected gross residual (R2), recurrent (> 6 months after surgery and/or completion of adjuvant therapy), or metastatic BTC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed in combination with gemcitabine and cisplatin;
- 5.1. Request meets one of the following (a, b, or c):*

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5. For brand Imfinzi requests, member must use generic durvalumab, if available, unless contraindicated or clinically significant adverse effects are experienced;

6. Request meets one of the following (a, b, or c):*

- For body weight < 30 kg: ~~dose~~Dose does not exceed 20 mg/kg every 3 weeks in combination with chemotherapy, then 20 mg/kg every 4 weeks as a single agent;
- For body weight ≥ 30 kg: ~~dose~~Dose does not exceed 1,500 mg every 3 weeks in combination with chemotherapy, then 1,500 mg every 4 weeks as a single agent;
- 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

D. Hepatocellular Carcinoma (must meet all):

- Diagnosis of unresectable, liver-confined, or metastatic ~~hepatocellular carcinoma~~HCC;
- Prescribed by or in consultation with an oncologist;
- Age ≥ 18 years;
4. For brand Imfinzi requests, member must use generic durvalumab, if available, unless contraindicated or clinically significant adverse effects are experienced;

5. Request meets one of the following (a, b, or c):*

- For body weight < 30 kg: ~~dose~~Dose does not exceed Imfinzi 20 mg/kg in combination with ~~tremelimumab-aetl~~Imjudo 4 mg/kg as a single dose at Cycle 1/Day 1, followed by Imfinzi as a single agent every 4 weeks;
- For body weight ≥ 30 kg: ~~dose~~Dose does not exceed Imfinzi 1,500 mg in combination with ~~tremelimumab-aetl~~Imjudo 300 mg as a single dose at Cycle 1/Day 1, followed by Imfinzi as a single agent every 4 weeks;
- Dose 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

E. Cervical Cancer (off-label) (must meet all):

- Diagnosis of persistent, recurrent, or metastatic small cell neuroendocrine carcinoma of the cervix (NECC);
- Prescribed by or in consultation with an oncologist;
- Age ≥ 18 years;
- Prescribed in combination with etoposide and either cisplatin or carboplatin;
5. For brand Imfinzi requests, member must use generic durvalumab, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Request meets one of the following (a or b):*
 - Dose does not exceed the FDA approved maximum recommended dose;
 - Dose 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. Gastric, Esophageal, and Esophagogastric Junction Cancer (off-label) (must meet all):

1. Diagnosis of gastric, esophageal, or esophagogastric junction adenocarcinoma;
 2. Prescribed by or in consultation with an oncologist;
 3. Age \geq 18 years;
 4. Prescribed in combination with Imjudo as neoadjuvant therapy;
 5. Disease is microsatellite instability-high (MSI-H) or deficient mismatch repair (dMMR);
 6. Provider attestation that member is medically fit for surgery;
 7. For brand Imfinzi requests, member must use generic durvalumab, if available, unless contraindicated or clinically significant adverse effects are experienced;
 8. Request meets one of the following (a or b):*
 - a. Dose does not exceed the FDA approved maximum recommended dose;
 - b. Dose 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. Ampullary Adenocarcinoma (off-label) (must meet all):

1. Diagnosis of ampullary adenocarcinoma (pancreatobiliary or mixed type);
 2. Prescribed by or in consultation with an oncologist;
 3. Age \geq 18 years;
 4. Prescribed in combination with gemcitabine and cisplatin;
 5. Disease is unresectable localized, stage IV resected, or metastatic;
 6. For brand Imfinzi requests, member must use generic durvalumab, if available, unless contraindicated or clinically significant adverse effects are experienced;
 - 5-7. Request meets one of the following (a or b):*
 - a. Dose does not exceed the FDA approved maximum recommended dose;
 - b. Dose 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.H. 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

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II. Continued Therapy

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

1. Currently receiving medication via Centene benefit, or member has previously met initial approval criteria, or documentation supports that member is currently receiving Imfinzi for a covered indication and has received this medication for at least 30 days;
2. For stage II—III NSCLC requests, member has not received more than 12 months of Imfinzi therapy;
3. Member is responding positively to therapy;
4. For brand Imfinzi requests, member must use generic durvalumab, if available, unless contraindicated or clinically significant adverse effects are experienced;

4.5. If request is for a dose increase, request meets one of the following (a, b, c, d, e, or f):*

- a. For stage II—III NSCLC (i or ii):
 - i. For body weight < 30 kg: ~~new~~New dose does not exceed 10 mg/kg every 2 weeks;
 - ii. For body weight ≥ 30 kg: ~~new~~New dose does not exceed 10 mg/kg every 2 weeks or 1,500 mg every 4 weeks;
- b. For metastatic NSCLC (i or ii):
 - i. For body weight < 30 kg: ~~new~~New dose does not exceed ~~Imfinzi~~ 20 mg/kg every 3 weeks in combination with ~~tremelimumab-aet~~Imjudo and platinum-based chemotherapy for 4 cycles, then ~~Imfinzi~~ 20 mg/kg every 4 weeks with histology-based pemetrexed maintenance therapy;
 - ii. For body weight ≥ 30 kg: ~~new~~New dose does not exceed ~~Imfinzi~~ 1,500 mg every 3 weeks in combination with ~~tremelimumab-aet~~Imjudo and platinum based chemotherapy for 4 cycles, then ~~Imfinzi~~ 1,500 mg every 4 weeks with histology-based pemetrexed maintenance therapy;
- c. For ES-~~NSCLC~~NSCLC (i or ii):
 - i. For body weight < 30 kg: ~~new~~New dose does not exceed 20 mg/kg every 3 weeks in combination with chemotherapy for 4 cycles, then 10 mg/kg every 2 weeks as a single agent;
 - ii. For body weight ≥ 30 kg: ~~new~~New dose does not exceed 1,500 mg every 3 weeks in combination with chemotherapy for 4 cycles, and then 1,500 mg every 4 weeks as a single agent;
- d. For BTC (i or ii):
 - i. For body weight < 30 kg: ~~new~~New dose does not exceed 20 mg/kg every 3 weeks in combination with chemotherapy, then 20 mg/kg every 4 weeks as a single agent;
 - ii. For body weight ≥ 30 kg: ~~new~~New dose does not exceed 1,500 mg every 3 weeks in combination with chemotherapy, then 1,500 mg every 4 weeks as a single agent;
- e. ~~uHCC~~For HCC (i or ii):
 - i. For body weight < 30 kg: ~~new~~New dose does not exceed 20 mg/kg in combination with ~~tremelimumab-aet~~Imjudo, then ~~20mg~~20 mg/kg every 4 weeks;

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- ii. For body weight ≥ 30 kg: ~~new~~New dose does not exceed 1,500 mg in combination with ~~tremelimumab~~ at ~~Imjudo~~, then 1,500 mg every 4 weeks;
- f. 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~~

~~*Prescribed regimen must be FDA-approved or recommended by NCCN~~

Approval duration:

Stage II-III NSCLC: up to a total duration of 12 months

All other indications: 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 2 above does not apply, refer to the off-label use policy LA.PMN.53

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

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALK: anaplastic lymphoma kinase

BTC: biliary tract cancer

ES-SCLC: extensive-stage small cell lung cancer

EGFR: epidermal growth factor receptor

FDA: Food and Drug Administration

NECC: neuroendocrine carcinoma of the cervix

NSCLC: non-small cell lung cancer

~~RT: radiotherapy~~

~~NECC: neuroendocrine carcinoma of the~~

~~uHCC: unresectable hepatocellular carcinoma~~

~~cervix~~

PD-L1: programmed death-ligand

RT: radiotherapy

uHCC: unresectable hepatocellular carcinoma

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
NSCLC (examples of concurrent platinum-containing/radiotherapy regimens)		
cisplatin, etoposide, RT	Varies	Varies

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Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
carboplatin/cisplatin, pemetrexed, RT		
paclitaxel, carboplatin, RT		
ES-SCLC (regimen examples as included in the NCCN SCLC guidelines)		
(carboplatin or cisplatin) and etoposide and Imfinzi	<p>Carboplatin AUC 5-6 day 1 and etoposide 80-100 mg/m² days 1, 2, 3 and Imfinzi 1,500 mg day 1 every 21 days x 4 cycles followed by maintenance Imfinzi 1,500 mg day 1 every 28 days</p> <p>Cisplatin 75-80 mg/m² day 1 and etoposide 80-100 mg/m² days 1, 2, 3 and Imfinzi 1,500 mg day 1 every 21 days x 4 cycles followed by maintenance Imfinzi 1,500 mg day 1 every 28 days</p>	See dosing regimens

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

None reported

Appendix D: General Information

- On February 22, 2021, AstraZeneca announced the voluntary withdrawal of the indication for Imfinzi for second-line treatment of locally advanced or metastatic bladder cancer. Imfinzi was approved for this indication under the accelerated pathway in 2017, based on study results that showed positive tumor response rates and duration of response. In its announcement, AstraZeneca pointed to results from the DANUBE confirmatory trial, in which Imfinzi failed to meet its key primary endpoint of overall survival.
- Actionable molecular biomarkers include EGFR, KRAS, ALK, ROS1, BRAF, NTRK1/2/3, MET, RET, and ERBB2 (HER2). If there is insufficient tissue to allow testing for all of EGFR, KRAS, ALK, ROS1, BRAF, NTRK1/2/3, MET, RET, and ERBB2 (HER2), repeat biopsy and/or plasma testing should be done. If these are not feasible, treatment is guided by available results and, if unknown, these patients are treated as though they do not have driver oncogenes.
- Contraindications for treatment with PD-1/PD-L1 inhibitors may include active or previously documented autoimmune disease and/or current use of immunosuppressive agents, and some oncogenic drivers (i.e., EGFR exon 19 deletion or exon 21 L858R, ALK rearrangements) have been shown to be associated with less benefit from PD-1/PD-L1 inhibitors.

Appendix E: Recommended Combination Regimens

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Tumor Histology	Patient Weight	Imfinzi Dosage	Tremelimumab-actl Dosage	Platinum-based Chemotherapy Regimen
Non-Squamous	≥ 30 kg	1,500 mg	75 mg	carboplatin & nab-paclitaxel OR
	< 30 kg	20 mg/kg	1 mg/kg	carboplatin or cisplatin & pemetrexed
Squamous	≥ 30 kg	1,500 mg	75 mg	carboplatin & nab-paclitaxel OR
	< 30 kg	20 mg/kg	1 mg/kg	carboplatin or cisplatin & gemcitabine

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
NSCLC	<p><u>Stage II-III:</u></p> <ul style="list-style-type: none"> Weight ≥ 30 kg: 10 mg/kg IV every 2 weeks or 1,500 mg every 4 weeks Weight < 30 kg: 10 mg/kg IV every 2 weeks <p><u>Metastatic:</u></p> <ul style="list-style-type: none"> Weight ≥ 30 kg: 1,500 mg every 3 weeks in combination with tremelimumab-actlImjudo 75 mg and platinum-based chemotherapy for 4 cycles, and then administer Imfinzi 1,500 mg every 4 weeks as a single agent with histology-based pemetrexed maintenance therapy every 4 weeks, and a fifth dose of tremelimumab-actlImjudo 75 mg in combination with Imfinzi dose 6 at week 16* Weight < 30 kg: 20 mg/kg every 3 weeks in combination with tremelimumab-actlImjudo 1 mg/kg and platinum-based chemotherapy, and then administer Imfinzi 20 mg/kg every 4 weeks as a single agent with histology-based pemetrexed therapy every 4 weeks, and a fifth dose of tremelimumab-actlImjudo 1 mg/kg in combination with Imfinzi dose 6 at week 16* 	<p>Stage II-III See regimen; maximum duration of 12 months</p> <p>Metastatic: see See regimen</p>
ES-SCLC	<ul style="list-style-type: none"> Weight ≥ 30 kg: 1,500 mg IV in combination with chemotherapy-† every 3 weeks (21 days) for 4 cycles, followed by 1,500 mg every 4 weeks as a single agent Weight < 30 kg: 20 mg/kg IV in combination with chemotherapy* every 3 weeks (21 days) for 4 cycles, following by 10 mg/kg every 2 weeks as a single agent 	See regimen

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Indication	Dosing Regimen	Maximum Dose
BTC	<ul style="list-style-type: none"> Weight \geq 30 kg: 1,500 mg IV every 3 weeks in combination with chemotherapy-†, then 1,500 mg every 4 weeks as a single agent Weight < 30 kg: 20 mg/kg IV every 3 weeks in combination with chemotherapy-†, then 20 mg/kg every 4 weeks as a single agent 	See regimen
uHCC	<ul style="list-style-type: none"> Weight \geq 30 kg: Imfinzi 1,500 mg in combination with tremelimumab-actl (Imjudo) 300 mg as a single dose at Cycle 1/Day 1, followed by Imfinzi as a single agent every 4 weeks Weight < 30 kg: Imfinzi 20 mg/kg in combination with tremelimumab-actl (Imjudo) 4 mg/kg as a single dose at Cycle 1/Day 1, followed by Imfinzi as a single agent every 4 weeks 	See regimen

* Optional pemetrexed therapy may be initiated from week 12 until disease progression or intolerable toxicity for patients with nonsquamous disease who received treatment with pemetrexed and carboplatin/cisplatin.
† Administer Imfinzi prior to chemotherapy on the same day. Refer to the Prescribing Information for the agent administered in combination with Imfinzi for recommended dosage information, as appropriate. [For ES-SCLC, see also Appendix B. Therapeutic Alternatives for NCCN regimens as carboplatin, cisplatin, and etoposide are off-label for this indication.]

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VI. Product Availability

Single-dose vials: 120 mg/2.4 mL, 500 mg/10 mL

VII. References

- Imfinzi Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; ~~November 2022~~ June 2023. Available at: <https://www.imfinzi.com>. Accessed January ~~5, 2023~~ 11, 2024.
- National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed ~~January 24, 2023~~ February 6, 2024.
- National Comprehensive Cancer Network. Non-Small Cell Lung Cancer Version ~~1.2023~~ 2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed ~~January 24, 2023~~ February 6, 2024.
- National Comprehensive Cancer Network. Small Cell Lung Cancer Version ~~3.2023~~ 2024. Available at: [https://www.nccn.org/professionals/physician_gls/pdf/~~nscl~~sccl.pdf](https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf). Accessed ~~January 24, 2023~~ February 6, 2024.
- National Comprehensive Cancer Network. ~~Hepatobiliary Cancers~~ Hepatocellular Carcinoma Version ~~5.2022~~ 2023. Available at: [https://www.nccn.org/professionals/physician_gls/pdf/~~hepatobiliary~~hcc.pdf](https://www.nccn.org/professionals/physician_gls/pdf/hepatobiliaryhcc.pdf). Accessed ~~January 24, 2023~~ February 6, 2024.

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6. National Comprehensive Cancer Network. ~~Cervical Cancer~~Biliary Tract Cancers Version ~~43~~43.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cervicalbtrc.pdf. Accessed ~~January 24, 2023~~February 6, 2024.

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.

HCPSC Codes	Description
J9173	Injection, durvalumab, 10 mg

<u>Reviews, Revisions, and Approvals</u>	<u>Date</u>	<u>LDH Approval Date</u>
Converted corporate to local policy	04.22	07.23.22
Added criteria for new FDA approved indication of BTC; added off-label criteria for hepatocellular carcinoma per NCCN 2A recommendation.	06.02.23	<u>10.05.23</u>
For NSCLC and ES-SCLC added age ≥ 18 years to be consistent with prescribing information.		
Template changes applied to other diagnoses/indications.		
Added criteria for newly FDA-approved indications for metastatic NSCLC and HCC; HCC converted from off-label to FDA approved status.		
For NSCLC per NCCN Compendium added recurrent or advanced disease and additional actionable molecular biomarkers that could be negative for use in combination with Imjudo and platinum therapy, added off-label continuation maintenance therapy; added off-label use for cervical cancer; clarified maximum 12 month continued approval duration applies only to stage II-III NSCLC.		
References reviewed and updated.		
<u>Annual review: per NCCN – for NSCLC, added recommended uses when actionable molecular biomarkers are present; for BTC, added resected gross residual (R2) disease; added off-label uses for gastric, esophageal, esophagogastric junction, and ampullary</u>	<u>05.07.24</u>	

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<u>adenocarcinoma; for all indications, added redirection to generic if available; references reviewed and updated.</u>		
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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.

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CLINICAL POLICY

Durvalumab

their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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