Medical Policy

Healthcare Services Department

Policy Name	Policy Number	Scope
Polatuzumab vedotin-piiq (Polivy®)	MP-RX-FP-73-23	☒ MMM MA ☒ MMM Multihealth

Service Category

☐ Anesthesia
☐ Surgery
☐ Radiology Procedures
☐ Pathology and Laboratory Procedures
☐ Medicine Services and Procedures
☐ Evaluation and Management Services
☐ DME/Prosthetics or Supplies
☒ Part B DRUG

Service Description

This document addresses the use of polatuzumab vedotin-piiq (Polivy®), a CD79b-directed antibody and microtubule inhibitor conjugate approved by the Food and Drug Administration (FDA) for the treatment of certain patients with diffuse large B-cell lymphoma (DLBCL), not otherwise specified (NOS) or high-grade B-cell lymphoma (HGBL), and patients with relapsed or refractory DLBCL, NOS, after at least two prior therapies.

Background Information

Polivy is a monoclonal antibody-drug conjugate (ADC) that consists of a humanized igG1 antibody specific for CD79b and a small molecule, monomethyl auristatin E (MMAE), a microtubule- disrupting agent. The anticancer activity is due to the binding of the ADC to CD79b-expressing cells, cleavage of MMAE component, and killing dividing cells by inhibiting cell division and inducing apoptosis. The target CD79b is a surface protein found exclusively on B- cells and Polivy is indicated to treat diffuse large B-cell lymphoma (DLBCL).

The FDA approved indications for Polivy include in combination with bendamustine and a rituximab product for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma, not otherwise specified, after at least two prior therapies. Accelerated approval was based on positive results from a phase 2 trial comparing Polivy plus bendamustine and rituximab (BR) to BR alone.

Patients included in this study were not eligible for autologous hematopoietic stem cell transplantation (HSCT). The National Comprehensive Cancer Network® (NCCN) provides additional recommendations with a category 2A level of evidence for the use of Polivy, noting it is an appropriate treatment option for patients with relapsed or refractory high-grade B-cell lymphoma with translocations of *MYC* and *BCL2* and/or *BCL6* (after ≥2 prior lines of therapy) ineligible for HSCT.

Abbreviations, Definitions and Measures

- DLBCL: Diffuse large B-cell lymphoma
- Hematopoietic stem cells: Primitive cells capable of replication and formation into mature blood cells in order to repopulate the bone marrow.
- HGBL: High-grade B-cell lymphoma
- Line of Therapy:
    - First-line therapy: The first or primary treatment for the diagnosis, which may include surgery, chemotherapy, radiation therapy or a combination of these therapies.

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  - Second-line therapy: Treatment given when initial treatment (first-line therapy) is not effective or there is disease progression.
  - Third-line therapy: Treatment given when both initial (first-line therapy) and subsequent treatment (second-line therapy) are not effective or there is disease progression.
- Monoclonal antibody: A protein developed in the laboratory that can locate and bind to specific substances in the body and on the surface of cancer cells.
- Non-Hodgkin Lymphoma (NHL): A group of malignant solid tumors or lymphoid tissues. Refractory Disease: Illness or disease that does not respond to treatment,
- NOS: Not otherwise specified
- Relapse or recurrence: After a period of improvement, during which time a disease (for example, cancer) could not be detected, the return of signs and symptoms of illness or disease. For cancer, it may come back to the same place as the original (primary) tumor or to another place in the body.

Approved Indications

Polatuzumab vedotin-piiq (Polivy®) is indicated by the FDA for the treatment of:

- Adult patients who have previously untreated diffuse large B-cell lymphoma (DLBCL), not otherwise specified (NOS) or high-grade B-cell lymphoma (HGBL) and who have an International Prognostic Index score of 2 or greater: in combination with a rituximab product, cyclophosphamide, doxorubicin, and prednisone (R-CHP).
- Adult patients with relapsed or refractory DLBCL, NOS, after at least two prior therapies: in combination with bendamustine and a rituximab product.

Other Uses

NCCN also recommends Polivy in other types of B-cell lymphoma including follicular lymphoma, AIDS-related lymphomas, and B-Cell Post-Transplant lymphoproliferative disorders. In addition, all NCCN recommendations have been updated to include the option of using Polivy as a single agent or in combination with bendamustine and/or rituximab. Polivy was studied as monotherapy very early in its development (NCT01290549), but more recent ongoing phase 2 and 3 studies are evaluating Polivy in various combination regimens. Further studies in larger populations are needed to determine the optimal combination regimen and place in therapy for Polivy in lymphomas other than DLBCL.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

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HCPCS	Description
J9309	Injection, polatuzumab vedotin-piiq, 1 mg [Polivy]

ICD-10	Description
C82.00-C82.99	Follicular Lymphoma
C83.30-C83.39	Diffuse large B-cell lymphoma
C85.10-C85.29	Unspecified B-cell lymphoma/ Mediastinal (thymic) large B-cell lymphoma

Medical Necessity Guidelines

When a drug is being reviewed for coverage under a member's medical benefit plan or is otherwise subject to clinical review (including prior authorization), the following criteria will be used to determine whether the drug meets any applicable medical necessity requirements for the intended/prescribed purpose.

Polatuzumab vedotin-piiq (Polivy®)

A. Criteria For Initial Approval (*Provider must submit documentation [such as office chart notes, lab results, pathology reports, imaging studies, and any other pertinent clinical information] supporting the patient's diagnosis for the drug and confirming that the patient has met **all** approval criteria.)*

i. Individual has a diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified (including high-grade B-cell lymphomas); **AND**
ii. Individual is using in combination with bendamustine and a rituximab (including rituximab biosimilars); **AND**
iii. Individual has received at least one prior lines of therapy (NCCN 2A); **AND**
iv. Individual is ineligible for autologous hematopoietic stem cell transplantation (HSCT);

OR

v. Individual has a diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified (including high-grade B-cell lymphomas); **AND**
vi. Individual is using as a bridging option (typically 1 or more cycles as necessary) until CAR T-cell product is available (NCCN 2A);

OR

vii. Individual has a diagnosis of diffuse large B-cell lymphoma (DLBCL), not otherwise specified (including high-grade B-cell lymphomas); **AND**
viii. Individual is using in combination with rituximab, cyclophosphamide, doxorubicin, and prednisone (Pola-R-CHP); **AND**
ix. Individual has international prognostic index for diffuse large B-cell Lymphoma (IPI) 2 or higher

OR

x. Individual has untreated large B-cell lymphoma (DLBCL), not otherwise specified (including high-grade B-cell lymphomas); **AND**

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xi. Individual is using in combination with rituximab, cyclophosphamide, doxorubicin, and prednisone (Pola-R-CHP); **AND**

xii. Individual has international prognostic index for diffuse large B-cell Lymphoma (IPI) 2 or higher.

B. Criteria For Continuation of Therapy

i. MMM considers continuation of Polatuzumab vedotin-piiq (Polivy®) therapy medically necessary in members requesting reauthorization for an indication listed in Section A above (Criteria for Initial Approval) when there is no evidence of an unacceptable toxicity or disease progression while on the current regimen, and the recommended duration of therapy has not been exceeded. The following information should be submitted for reauthorization:

A. A current oncology note documenting the patient's response to treatment showing no progression of disease

B. Current imaging studies and other objective measures showing no progression of disease when compared with previous results

ii. Consistent with the product FDA approved information, MMM considers continuation of Polatuzumab vedotin-piiq (Polivy) therapy medically necessary for up to 6 months (6 cycles total).

C. Authorization Duration

i. Initial Approval Duration: Per Cycle

ii. Reauthorization Approval Duration: Per Cycle

D. **Conditions Not Covered**

Any other use is considered experimental, investigational, or unproven, including the following (this list may not be all inclusive):

i. Requests for Polatuzumab vedotin-piiq (Polivy) may not be approved when the above criteria (Section A: Criteria for Initial Approval) are not met and for all other indications.

Limits or Restrictions

A. Quantity Limitations

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines. The chart below includes dosing recommendations as per the FDA-approved prescribing information.

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Drug	Co-administered Medications	Recommended Dosing Schedule	Recommended Treatment Duration
Patients with Previously Untreated DLBCL, NOS or HGBL	A rituximab product, cyclophosphamide, doxorubicin, and prednisone	1.8 mg/kg as an intravenous infusion every 21 days	6 Cycles
Patients with Relapsed or Refractory DLBCL, NOS	bendamustine and a rituximab product	1.8 mg/kg as an intravenous infusion every 21 days	6 Cycles
Exceptions			
None			

Reference Information

1. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2023. URL: http://www.clinicalpharmacology.com. Updated periodically.
2. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Updated periodically.
3. DrugPoints® System [electronic version]. Truven Health Analytics, Greenwood Village, CO. Updated periodically.
4. Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2023; Updated periodically.
5. Morschhauser F, Flinn IW, Advani R, et al. Polatuzumab vedotin or pinatuzumab vedotin plus rituximab in patients with relapsed or refractory non-Hodgkin lymphoma: final results from a phase 2 randomised study (ROMULUS). Lancet Haematol. 2019 May;6(5):e254-e265. doi: 10.1016/S2352-3026(19)30026-2. Epub 2019 Mar 29.
6. Sehn LH, Herrera AF, Flowers CR, et al. Polatuzumab Vedotin in Relapsed or Refractory Diffuse Lage B-Cell Lymphoma. J Clin Oncol 2020; 38:155-165.
7. NCCN Clinical Practice Guidelines in Oncology™. © 2021 National Comprehensive Cancer Network, Inc. For additional information visit the NCCN website: http://www.nccn.org/index.asp. Accessed June 21, 2023.
    a. B-cell Lymphomas. V4.2023. Revised June 2, 2023.

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Policy History

Revision Type	Summary of Changes	P&T Approval Date	MPCC Approval Date
Policy Inception	Elevance Health's Medical Policy adoption.	N/A	11/30/2023
Select Review	Update statement for criteria for initial approval: Provider must submit documentation [such as office chart notes, lab results, pathology reports, imaging studies, and any other pertinent clinical information] supporting the patient's diagnosis for the drug and confirming that the patient has met all approval criteria.	3/25/2024	5/9/2024

Revised: 11/11/2023