Clinical Policy: Avelumab (Bavencio)

Reference Number: ERX.SPA.299
Effective Date: 03.01.19
Last Review Date: 02.22
Line of Business: Commercial, Medicaid

Revision Log

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

Description
Avelumab (Bavencio®) is a programmed death ligand-1 blocking antibody.

FDA Approved Indication(s)
Bavencio is indicated for:

- Adults and pediatric patients 12 years and older with metastatic Merkel cell carcinoma (MCC).*
- Maintenance treatment of patients with locally advanced or metastatic urothelial carcinoma (UC) that has not progressed with first-line platinum-containing chemotherapy.
- Patients with locally advanced or metastatic UC who:
  - Have disease progression during or following platinum-containing chemotherapy.
  - Have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.
- First-line treatment, in combination with axitinib, of patients with advanced renal cell carcinoma (RCC).

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

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.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Bavencio is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Merkel Cell Carcinoma (must meet all)**:**

1. Diagnosis of metastatic MCC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 12 years;
4. Request meets one of the following (a or b):*
   a. Dose does not exceed 800 mg every two weeks;
   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

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

1. Diagnosis of recurrent, advanced, or metastatic UC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Member has received platinum-based chemotherapy (e.g., cisplatin, carboplatin);
5. Prescribed as a single agent;

6. Request meets one of the following (a or b):*
   a. Dose does not exceed 800 mg every two weeks;
   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

C. Renal Cell Carcinoma (must meet all)**:**
1. Diagnosis of advanced RCC (e.g., relapse, stage IV disease);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed as first-line therapy in combination with Inlyta®;

   **Prior authorization may be required for Inlyta*
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 800 mg every two weeks;
   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

D. Other NCCN Recommended Uses (off-label) (must meet all)**:**
1. Diagnosis of one of the following (a or b):
   a. Gestational trophoblastic neoplasia;
   b. Endometrial carcinoma;
2. Prescribed or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For gestational trophoblastic neoplasia: Prescribed as a single agent following failure of ≥ 2 systemic chemotherapeutic agents (see *Appendix B*);
5. For endometrial carcinoma, both of the following (a and b):
   a. Prescribed as a single agent second-line treatment (see *Appendix B*);
   b. Disease is recurrent or metastatic for microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) tumors;
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 800 mg every two weeks;
   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

E. Other diagnoses/indications
1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions, or documentation supports that member is currently receiving Bavencio for a covered indication 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 or b):*
   a. New dose does not exceed 800 mg every two weeks;
   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

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.
Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 – ERX.PA.01 or evidence of coverage documents.

IV. Appendices/General Information
Appendix A: Abbreviation/Acronym Key

dMMR: deficient mismatch repair
FDA: Food and Drug Administration
MCC: Merkel cell carcinoma
MSI-H: microsatellite instability-high
NCCN: National Comprehensive Cancer Network
RCC: renal cell carcinoma
UC: urothelial 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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Gestational Trophoblastic Neoplasia		
Examples of systemic chemotherapeutic agents: bleomycin, carboplatin, cyclophosphamide, dactinomycin, etoposide, gemcitabine, ifosfamide, mesna, methotrexate, paclitaxel, vincristine.	Varies	Varies
Endometrial Carcinoma		
Examples of systemic chemotherapeutic agents: carboplatin/paclitaxel, cisplatin/doxorubicin, carboplatin/paclitaxel/bevacizumab, doxorubicin, topotecan, temsirolimus, ifosfamide	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
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MCC, UC	800 mg IV infusion every 2 weeks until disease progression or unacceptable toxicity	800 mg every 2 weeks
RCC	800 mg IV infusion every 2 weeks in combination with axitinib	800 mg every 2 weeks

VI. Product Availability
Single-dose vial: 200 mg/10 mL (20 mg/mL)

VII. References
1. Bavencio Prescribing Information. Rockland, MA: EMD Serono, Inc.; November 2020. Available at: https://www.bavencio.com/. Accessed November 11, 2021.

2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed November 11, 2021.
3. National Comprehensive Cancer Network. Merkel Cell Carcinoma Version 1.2021. Available at www.nccn.org. Accessed November 11, 2021.
4. National Comprehensive Cancer Network. Bladder Cancer Version 5.2021. Available at: www.nccn.org. Accessed November 11, 2021.
5. National Comprehensive Cancer Network. Endometrial Carcinoma Version 1.2022. Available at www.nccn.org. Accessed November 11, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	11.13.18	02.19
RT4: criteria added for new FDA-approved indication for RCC; references reviewed and updated.	05.29.19	
1Q 2020 annual review: examples added per NCCN for advanced RCC - limited to first-line therapy per PI and NCCN; references reviewed and updated.	11.19.19	02.20
RT4: criteria updated for newly FDA-approved indication for maintenance treatment of UC for those who have not progressed after platinum therapy.	09.15.20	
1Q 2021 annual review: for UC, recurrent disease added per NCCN, and platinum-based chemotherapy history added per label and NCCN; gestational trophoblastic neoplasia off-label use added per NCCN; references reviewed and updated.	11.06.20	02.21
1Q 2022 annual review: added criterion that Bavencio be used as single-agent therapy for urothelial carcinoma per NCCN; added endometrial carcinoma indication per NCCN; references reviewed and updated.	11.11.21	02.22

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.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.