

## **Clinical Policy: Enfortumab Vedotin-ejfv (Padcev)**

Reference Number: CP.PHAR.455

Effective Date: 03.01.20

Last Review Date: 02.21

Line of Business: HIM, Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Enfortumab vedotin-ejfv (Padcev<sup>™</sup>) is a Nectin-4-directed antibody and microtubule inhibitor conjugate.

### **FDA Approved Indication(s)**

Padcev is indicated for the treatment of adult patients with locally advanced or metastatic urothelial cancer who:

- have previously received a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor, and a platinum-containing chemotherapy, or
- are ineligible for cisplatin-containing chemotherapy and have previously received one or more prior lines of therapy.

### **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 health plans affiliated with Centene Corporation<sup>®</sup> that Padcev is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

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

1. Diagnosis of one of recurrent, locally advanced or metastatic (stage IV) urothelial carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age  $\geq$  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 (*see Appendix B*);
    - ii. Programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor (*see Appendix B*);
  - b. Member is ineligible for cisplatin-containing chemotherapy and has previously received one or more prior lines of therapy (*see Appendix B*);
5. Request meets one of the following (a or b):\*
  - 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. 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**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

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

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Padcev 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 1.25 mg/kg (up to 125 mg) on Days 1, 8 and 15 of a 28-day cycle;
  - 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 Centene 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 for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PA.154 for health insurance marketplace and CP.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 – HIM.PA.154 for health insurance marketplace and CP.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/<br>Maximum<br>Dose |
|---|---------------------------------------|--------------------------------|
| <b>Examples of platinum-containing regimens</b>                           |                                       |                                |
| DDMVAC (dose-dense methotrexate, vinblastine, doxorubicin, and cisplatin) | Varies                                | Varies                         |
| gemcitabine with either cisplatin or carboplatin                          | Varies                                | Varies                         |
| <b>Examples of PD-1 and PD-L1 inhibitors</b>                              |                                       |                                |
| Keytruda <sup>®</sup> (pembrolizumab)                                     | Varies                                | Varies                         |
| Tecentriq <sup>®</sup> (atezolizumab)                                     | Varies                                | Varies                         |
| Opdivo <sup>®</sup> (nivolumab)   | Varies                                | Varies                         |
| Imfinzi <sup>®</sup> (durvalumab)   | 10 mg/kg IV infusion every 2 weeks    | Varies                         |
| Bavencio <sup>®</sup> (avelumab)  | 800 mg IV infusion once every 2 weeks | Varies                         |
| <b>Other recommended regimens</b>   |                                       |                                |
| gemcitabine   | Varies                                | Varies                         |
| gemcitabine and paclitaxel  | Varies                                | Varies                         |
| ifosfamide, doxorubicin, gemcitabine                                      | Varies                                | Varies                         |

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) 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       |
|-------------------|--|--------------------|
| 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 | 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; July 2021. Available at: <https://www.padcev.com>. Accessed July 28, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: [http://www.nccn.org/professionals/drug\\_compendium](http://www.nccn.org/professionals/drug_compendium). Accessed July 28, 2021.

3. National Comprehensive Cancer Network. Bladder Cancer Version 4.2021. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/bladder.pdf](https://www.nccn.org/professionals/physician_gls/pdf/bladder.pdf). Accessed July 28, 2021.
4. Micromedex<sup>®</sup> Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed July 28, 2021.

**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   |
|-------------|---|
| TBD         | Injection, enfortumab vedotin-ejfv, 10 mg                 |
| J9999       | Injection, not otherwise classified, antineoplastic drugs |

| Reviews, Revisions, and Approvals  | Date     | P&T Approval Date |
|--|----------|-------------------|
| Policy created.  | 01.14.20 | 02.20             |
| 1Q 2021 annual review: recurrent UC added and trial settings (e.g., neoadjuvant) removed to encompass NCCN recommended uses; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated. | 11.10.20 | 02.21             |
| RT4: added additional urothelial cancer indication in patients ineligible for cisplatin-containing chemotherapy and have previously received one or more prior lines of therapy                                | 07.28.21 |                   |

**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. The Health Plan 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. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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This clinical policy is effective as of the date determined by the Health Plan. 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. The Health Plan 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.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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