

Drug and Biologic Coverage Policy



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Coverage Policy Number 1403

Oncology Medications

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Related Coverage Resources

[Interferon Therapy – \(1315\)](#)
[Lanreotide for Non-Oncology indications – \(9005\)](#)
[Pharmacy Prior Authorization – \(1407\)](#)
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[Scar Revision – \(0328\)](#)
[Step Therapy – Legacy Prescription Drug Lists
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[Vascular Endothelial Growth Factor \(VEGF\) Inhibitors
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INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This coverage policy addresses medications used for the primary treatment of cancer. This coverage policy also addresses select anticancer medications used for non-oncology related symptoms.

- I. [Primary Treatment of Cancer](#)
- II. [Uses Not Associated with Cancer](#)

Coverage Policy

I. Primary Treatment of Cancer

Oncology Medications are considered medically necessary when **BOTH** of the following criteria are met:

- a. For **ONE** of the below indications or uses:
 - i. Use is an approved drug or biologic indication by the Food and Drug Administration (FDA).

- ii. Use is a category 1, 2A, or 2B recommendation by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®) or its derivative information product, The NCCN Drugs & Biologics Compendium (NCCN Compendium®).
- iii. Use is an accepted off-label pediatric oncology use and ALL of the following
 1. The drug is FDA approved for at least one indication
 2. The drug has not been contraindicated or not recommended by the FDA for the off-label use
 3. Supported by one of the following:
 - A. Compendia recognized by federal Centers for Medicare and Medicare Services (CMS) as part of an anticancer chemotherapeutic regimen (AHFS, Clinical Pharmacology, DrugDex, etc.)
 - B. Results of at least two different controlled clinical studies published in peer reviewed English-language, biomedical journal(s) analyzed as supporting the off label use where consideration is given to quality of evidence, validity of the data, efficacy, and safety of the drug in specific patient populations and how well the study was designed to assess the intervention, including analysis of baseline patient characteristics, patient withdrawals, and meaningful clinical outcome
 - C. Established as standard of care as analyzed in (ii) from clinical practice guidelines from professional or medical specialty societies, national government supported evidence assessments or guidelines
- b. Use of certain medications may require additional medical necessity determination; see criteria, if any, under specific medication listing:

| Drug/Biologic | Specific Additional Criteria |
|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Bosulif® (bosutinib) | <p>For Chronic Myeloid Leukemia (CML) Initial Therapy for Chronic Phase:</p> <ul style="list-style-type: none"> Initial authorization for 12 months. Reauthorization for an additional 12 months requires no evidence of disease progression (for example: monitoring response milestones per NCCN recommendations). <p>For Chronic Myeloid Leukemia (CML) Second-Line or Subsequent Therapy for Chronic Phase:</p> <ul style="list-style-type: none"> Treatment is recommended by NCCN based on documented BCR-ABL kinase domain mutation Initial authorization for 12 months. Reauthorization for an additional 12 months requires no evidence of disease progression (for example: monitoring response milestones per NCCN recommendations). |
| Gleevec® (imatinib) | <p>For Chronic Myeloid Leukemia (CML) Initial Therapy for Chronic Phase:</p> <ul style="list-style-type: none"> Initial authorization for 12 months Reauthorization for an additional 12 months requires no evidence of disease progression (for example: monitoring response milestones per NCCN recommendations) <p><i>*Coverage of the brand may require the use of preferred product(s). See table below.</i></p> |
| Iclusig® (ponatinib) | <p>For Chronic Myeloid Leukemia (CML) Second-Line or Subsequent Therapy for Chronic Phase:</p> <ul style="list-style-type: none"> Treatment is recommended by NCCN based on documented BCR-ABL kinase domain mutation Initial authorization for 12 months. |

| Drug/Biologic | Specific Additional Criteria |
|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | <ul style="list-style-type: none"> Reauthorization for an additional 12 months requires no evidence of disease progression (for example: monitoring response milestones per NCCN recommendations). |
| Imatinib mesylate | <p>For Chronic Myeloid Leukemia (CML) Initial Therapy for Chronic Phase:</p> <ul style="list-style-type: none"> Initial authorization for 12 months. Reauthorization for an additional 12 months requires no evidence of disease progression (for example: monitoring response milestones per NCCN recommendations). |
| Orgovyx (relugolix) | <p>For Prostate Cancer, BOTH of the following:</p> <ul style="list-style-type: none"> Individual is 18 years of age or older Individual has advanced disease. <p>Note: Advanced disease is defined as disease that has spread to other parts of the body, beyond the prostate. It can also include patients with persistent prostate specific antigen (PSA) levels or rising PSA levels after radiotherapy or surgery. Metastatic disease is also considered as advanced disease.</p> |
| Sprycel® (dasatinib) | <p>For Chronic Myeloid Leukemia (CML) Initial Therapy for Chronic Phase:</p> <ul style="list-style-type: none"> Initial authorization for 12 months. Reauthorization for an additional 12 months requires no evidence of disease progression (for example: monitoring response milestones per NCCN recommendations). <p>For Chronic Myeloid Leukemia (CML) Second-Line or Subsequent Therapy for Chronic Phase:</p> <ul style="list-style-type: none"> Treatment is recommended by NCCN based on documented BCR-ABL kinase domain mutation Initial authorization for 12 months. Reauthorization for an additional 12 months requires no evidence of disease progression (for example: monitoring response milestones per NCCN recommendations). |
| Tasigna® (nilotinib) | <p>For Chronic Myeloid Leukemia (CML) Initial Therapy for Chronic Phase:</p> <ul style="list-style-type: none"> Initial authorization for 12 months. Reauthorization for an additional 12 months requires no evidence of disease progression (for example: monitoring response milestones per NCCN recommendations). <p>For Chronic Myeloid Leukemia (CML) Second-Line or Subsequent Therapy for Chronic Phase:</p> <ul style="list-style-type: none"> Treatment is recommended by NCCN based on documented BCR-ABL kinase domain mutation. Initial authorization for 12 months. Reauthorization for an additional 12 months requires no evidence of disease progression (for example: monitoring response milestones per NCCN recommendations). |

- c. Coverage for Oncology Medications varies across plans. Refer to the customer's benefit plan document for coverage details. Refer to the following tables for pharmacy and medical benefit preferred products coverage criteria for primary treatment of cancer.

Where coverage requires the use of preferred products eligible for pharmacy benefit coverage, the following criteria apply:

| Drug/Biologic | Standard Drug List Performance Drug List | Value Drug List Advantage Drug List | Legacy Drug List Plan | Cigna Total Savings | Individual and Family Plans |
|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| Cyclophosphamide tablets | Unable to use cyclophosphamide capsules | | | | Cyclophosphamide tablets are covered |
| Gleevec® (imatinib) | Documented intolerance to generic imatinib. | | | | |
| Infugem™ (gemcitabine) | Documented intolerance to one generic formulation of Gemzar. | | | | |
| Kisqali® (ribociclib) | For Employer Group Benefit Plans Only. EITHER of the following are met: <ul style="list-style-type: none"> Individual has previously been started on, or is currently receiving ribociclib (Kisqali) Individual has a documented trial for abemaciclib (Verzenio) or palbociclib (Ibrance) | | | | Kisqali is covered when medical necessity coverage criteria in Section Ia and Ib are met. |
| Kisqali® Femara® Co-Pack (ribociclib tablets; letrozole tablets) | For Employer Group Benefit Plans Only. EITHER of the following are met: <ul style="list-style-type: none"> Individual has previously been started on, or is currently receiving ribociclib tablets; letrozole tablets (Kisqali Femara Co-Pack) Individual has documented trials for abemaciclib (Verzenio) or palbociclib (Ibrance) in combination with an aromatase inhibitor (for example, anastrozole, letrozole) | | | | Kisqali Femara Co-Pack is covered when medical necessity coverage criteria in Section Ia and Ib are met. |
| Nilandron® (nilutamide) | BOTH of the following are met: <ul style="list-style-type: none"> Documented intolerance to one generic formulation of Nilandron Documented failure/inadequate response, contraindication per FDA label, intolerance or not a candidate for bicalutamide or flutamide | | | | |
| Orgovyx (relugolix) | ONE of the following: <ul style="list-style-type: none"> Documented failure/inadequate response, contraindication per FDA label, intolerance or not a candidate for ONE of the following*: Lupron Depot, Trelstar, Firmagon, or Eligard According to the prescriber, the individual is at risk of cardiovascular disease Individual is using for intermittent androgen deprivation therapy Individual is currently receiving therapy with Orgovyx *May require prior authorization | | | | |
| Pomalyst® (pomalidomide) | Non-Preferred Brand | Non-Preferred Brand | Non-Preferred Brand | ANY of the following are met: <ul style="list-style-type: none"> Individual has been started on Pomalyst For treatment of Multiple Myeloma AND the individual has tried Revlimid For treatment of | Pomalyst (brand) is covered when above medical necessity coverage criteria in Section Ia and Ib are met. |

| Drug/Biologic | Standard Drug List Performance Drug List | Value Drug List Advantage Drug List | Legacy Drug List Plan | Cigna Total Savings | Individual and Family Plans |
|--------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| | | | | Kaposi Sarcoma, Central Nervous System Lymphoma, or Systemic Light Chain Amyloidosis | |
| Tarceva® (erlotinib) | For Employer Group Benefit Plans Only. Documented intolerance to generic erlotinib. | | | | Tarceva (brand) is covered when above medical necessity coverage criteria in Section Ia and Ib are met. |
| Targretin® (bexarotene) | Documented intolerance to generic bexarotene. | | | | |
| Temodar® (temozolomide) | Documented intolerance to generic temozolomide. | | | | |
| Tykerb® (lapatinib) | Documented intolerance to generic lapatinib. | | | | |
| Xeloda® (capecitabine) | Documented intolerance to generic capecitabine. | | | | |
| Xtandi® (enzalutamide) | For castration-recurrent metastatic prostate cancer ONLY: BOTH of the following are met: <ul style="list-style-type: none"> ONE of the following: <ul style="list-style-type: none"> Individual has previously been started on, or is currently receiving enzalutamide (Xtandi) Documented failure/inadequate response, contraindication per FDA label, intolerance or not a candidate (for example: unable to use prednisone) for abiraterone (Zytiga®). Xtandi will not be concomitantly administered with Zytiga. | | | | |
| Yonsa® (abiraterone) | Documented intolerance to the generic formulation of Zytiga (abiraterone). | | | | |
| Zytiga® (abiraterone) | Documented intolerance to the generic formulation of Zytiga (abiraterone). | | | | |

Where coverage requires the use of preferred products eligible for medical benefit coverage, the following criteria apply:

| Drug/Biologic | Employer Group Plans | Individual and Family Plans |
|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| Avastin® (bevacizumab) | EITHER of the following are met: <ul style="list-style-type: none"> Individual has previously been started on, or is currently receiving bevacizumab (Avastin) Individual has documented trials for Mvasi (bevacizumab-awwb) AND Zirabev (bevacizumab-bvzr) | |

| Drug/Biologic | Employer Group Plans | Individual and Family Plans |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| Fusilev® (levoleucovorin) Khapzory™ (levoleucovorin) | Unable to obtain leucovorin injection due to a documented drug shortage (Food and Drug Administration [FDA] Drug Shortage database or American Society of Health-Systems Pharmacists [ASHP] Drug Shortage list). | |
| Herceptin® (trastuzumab) | EITHER of the following are met: <ul style="list-style-type: none"> Individual has previously been started on, or is currently receiving trastuzumab (Herceptin) Individual has documented trials for Kanjinti (trastuzumab-anns) AND Trazimera (trastuzumab-qyyp) | |
| Herceptin Hylecta™ (trastuzumab and hyaluronidase-oysk) | EITHER of the following are met: <ul style="list-style-type: none"> Individual has previously been started on, or is currently receiving trastuzumab and hyaluronidase-oysk (Herceptin Hylecta) Individual has documented trials for Kanjinti (trastuzumab-anns) AND Trazimera (trastuzumab-qyyp) | |
| Herzuma® (trastuzumab-pkrb) | EITHER of the following are met: <ul style="list-style-type: none"> Individual has previously been started on, or is currently receiving trastuzumab-pkrb (Herzuma) Individual has documented trials for Kanjinti (trastuzumab-anns) AND Trazimera (trastuzumab-qyyp) | |
| Ogivri (trastuzumab-dkst) | EITHER of the following are met: <ul style="list-style-type: none"> Individual has previously been started on, or is currently receiving trastuzumab-dkst (Ogivri) Individual has documented trials for Kanjinti (trastuzumab-anns) AND Trazimera (trastuzumab-qyyp) | |
| Ontruzant® (trastuzumab-dttb) | EITHER of the following are met: <ul style="list-style-type: none"> Individual has previously been started on, or is currently receiving trastuzumab-dttb (Ontruzant) Individual has documented trials for Kanjinti (trastuzumab-anns) AND Trazimera (trastuzumab-qyyp) | |
| Rituxan® (rituximab) | ANY of the following are met: <ul style="list-style-type: none"> Individual has previously been started on, or is currently receiving rituximab (Rituxan) Individual has documented trials for ALL of the following: Riabni (rituximab-arx) AND Ruxience (rituximab-pvvr) AND Truxima (rituximab-abbs) | |
| Rituxan Hycela™ (rituximab and hyaluronidase human) | EITHER of the following are met: <ul style="list-style-type: none"> Individual has previously been started on, or is currently receiving rituximab and hyaluronidase (Rituxan Hycela) Treatment is for a malignancy and BOTH of the following: <ul style="list-style-type: none"> The individual has received at least one dose of intravenous rituximab Individual has documented trials for ALL of the following: Riabni (rituximab-arx) AND Ruxience (rituximab-pvvr) AND Truxima (rituximab-abbs) | |
| Sandostatin LAR Depot (octreotide injectable suspension) | Effective 10/1/2021: ONE of the following are met: <ol style="list-style-type: none"> Individual has documented trial of Somatuline Depot (lanreotide) injection Individual with meningioma Individual with thymoma/thymic carcinoma Individual has previously been started on, or is currently receiving Sandostatin LAR Depot | |

II. Uses Not Associated with Cancer

Use of certain Oncology Medications for treatment or symptoms not associated with cancer may require medical necessity determination; see medical necessity criteria, if any, under the specific medication listing:

| Drug/Biologic | Uses Not Associated with Cancer Criteria |
|-----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Bleomycin (bleomycin sulfate) | Treatment for symptomatic recalcitrant verruca vulgaris (unresponsive to all other treatments). <i>For scar revision, please refer to Scar Revision – (0328)</i> |
| Cyclophosphamide tablets | Unable to use cyclophosphamide capsules |
| Fluorouracil | <i>For scar revision, please refer to Scar Revision – (0328)</i> |
| Jakafi® (ruxolitinib) | BOTH of the following are met: <ul style="list-style-type: none"> • Treatment for graft-versus-host disease (GVHD) • Documented failure/inadequate response, contraindication per FDA label, intolerance or not a candidate for one systemic corticosteroid. |

The following medications for the treatment of non-oncological uses are addressed in separate coverage policies. Please refer to the related coverage policy links above.

- Lupron®, Lupron Depot, Lupron Depot-Ped (leuprolide acetate)
- Supprelin® LA, Vantas® (histrelin acetate)
- Zoladex® (goserelin acetate)

Initial authorization is up to 12 months unless otherwise stated.

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Oncology Medications for uses that are an NCCN category 3 recommendation (unless the use is approved by the FDA) are not covered because they are considered not medically necessary.

Olaratumab (Lartruvo) is considered not medically necessary for any use as it is no longer recommended for treatment initiation by the FDA or NCCN. Beginning April 25, 2019, olaratumab will be withdrawn from the market for the treatment of advanced soft tissue sarcoma (STS) due to the failure of the Phase 3 ANNOUNCE clinical trial in which Lartruvo did not improve survival for patients.

Oncology Medications are considered experimental, investigational or unproven for ANY other use.

Note: Receipt of sample product does not satisfy any criteria requirements for coverage

FDA Approved Indications

FDA Approved Indication

Drugs

Drugs@FDA.

<http://www.accessdata.fda.gov/scripts/cder/drugsatfda/>

Biologics

Licensed Biological Products with Supporting Documents.

<http://www.fda.gov/BiologicsBloodVaccines/ucm133705.htm>

General Background

Professional Societies/Organizations

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®) [available with free subscription]
http://www.nccn.org/professionals/physician_gls/f_guidelines.asp

The NCCN Drugs & Biologics Compendium (NCCN Compendium®) [available with paid subscription]
http://www.nccn.org/professionals/drug_compendium/content/contents.asp

The National Comprehensive Cancer Network® (NCCN®) is an organization of cancer centers, developing treatment guidelines for most cancers. The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) present evidenced-based recommendations for the diagnosis and treatment of cancer and cancer care supportive therapies. NCCN provides the following definitions for their categories of recommendations:

- Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate;
- Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate;
- Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate;
- Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

For the 'uniform NCCN consensus' defined in Category 1 and Category 2A, a majority Panel vote of at least 85% is required. For the 'NCCN consensus' defined in Category 2B, a Panel vote of at least 50% (but less than 85%) is required. Lastly, for recommendations where there is strong Panel disagreement regardless of the quality of the evidence, NCCN requires a vote from at least three Panel Members (representing at least three different Member Institutions) to include and designate a recommendation as Category 3. The large majority of the recommendations put forth in the Guidelines are Category 2A. Where categories are not specified within the Guidelines, the default designation for the recommendation is Category 2A. (NCCN, 2020)

The NCCN Drugs & Biologics Compendium (NCCN Compendium®) includes FDA Approved Indications of cancer and cancer support medications and recommended non-FDA approved uses based upon the recommendations contained within the NCCN Guidelines.

- **Chronic Myeloid Leukemia**

NCCN categorizes chronic myeloid leukemia as either chronic phase or advanced phase. For chronic phase CML, a risk score is calculated using either Sokal or Hasford to aid in primary treatment selection. For low-risk or intermediate- or high-risk initial therapy for CML, NCCN recommends first generation tyrosine kinase inhibitor (TKI) (imatinib or generic imatinib); second generation TKI (bosutinib, dasatinib, nilotinib) or clinical trial. NCCN notes that individuals with an intermediate- or high-risk score may preferentially benefit from a second generation TKI. (NCCN, 2017c)

NCCN advocates evaluating reaction to therapy using response milestones. Based on this information, mutation testing is recommended when there is failure or inadequate response to first line therapy. NCCN offers specific treatment regimens based on the results of the mutation analysis. (NCCN, 2017c)

- **Fusilev, Khapzory**

Levoleucovorin has 2A recommendations in osteosarcoma, colon cancer, and rectal cancer when leucovorin is not available.

- **Gleevec**

The FDA approved generic imatinib, which is considered to be a therapeutic equivalent for all approved indications for Gleevec except for gastrointestinal stromal tumors (GIST). However, the FDA lists imatinib generics classified in its Orange Book, or Approved Drug Products with Therapeutic Equivalence Evaluations, as therapeutic equivalents. Per the FDA, drug products are considered to be therapeutic equivalents only if they are pharmaceutical equivalents for which bioequivalence has been demonstrated, and they can be expected to have the same clinical effect and safety profile when administered to individuals under the conditions specified in the labeling.

FDA conducts post marketing drug and biologic safety surveillance. Types of information considered include reports made to the FDA Adverse Event Reporting System (FAERS) and medical literature. FDA evaluates each potential safety concern and may issue additional public communications as appropriate. There are no current reports challenging the safety of imatinib. (FDA, 2017)

Evidence based clinical guidelines, such as NCCN and ASCO (American Society of Clinical Oncology), discuss the various uses of drugs and biologics and make recommendations for imatinib without specification for brand-only usage requirements. (NCCN, 2017; ASCO, 2017)

Imatinib is considered to be a therapeutic alternative to Gleevec. Therapeutic alternatives can be expected to have similar outcomes and adverse reaction profiles and are determined from FDA approved product information, pharmaceutical compendia sources, clinical practice guidelines, and peer-reviewed published studies.

- **Jakafi**

Jakafi, a kinase inhibitor, is indicated for treatment of individuals with 1) intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis, 2) polycythemia vera in individuals who have had an inadequate response to or are intolerant of hydroxyurea, and 3) steroid-refractory acute graft-vs.-host disease in adult and pediatric individuals ≥ 12 years of age. Jakafi specifically inhibits Janus Associated Kinases (JAKs) JAK1 and JAK2 which mediate the signaling of various cytokine and growth factors that are vital for hematopoiesis and immune function.

- **Kisqali**

NCCN does not recommend an additional line of therapy with another CDK4/6-containing regimen if there is disease progression while on CDK4/6 inhibitor therapy. The organization does not state a preference for one CDK4/6 inhibitor therapy over another. (NCCN, 2019a)

- **Lartruvo**

On January 24, 2019, the U.S. Food and Drug Administration (FDA) announced that it no longer recommends olaratumab be initiated as new start treatment outside of an investigational trial. Lartruvo was initially approved under FDA's accelerated approval program for use in combination with doxorubicin for treatment of certain individuals with soft tissue sarcoma. The results of a larger confirmatory trial recently completed did not demonstrate benefit of Lartruvo. (FDA, 2019)

Version 2.2019 of the NCCN Soft Tissue Sarcoma Guidelines no longer recommend the combination regimen of doxorubicin and olaratumab for treatment of soft tissue sarcoma. (NCCN, 2019b)

On April 25, 2019 Eli Lilly and Company announced that the company has been working to facilitate the withdrawal of Lartruvo (olaratumab) from the market for the treatment of advanced soft tissue sarcoma (STS) due to the failure of the Phase 3 ANNOUNCE clinical trial in which Lartruvo did not improve survival for individuals.

- **Nilandron**

NCCN makes the following recommendations for anti-androgen therapy:

- Systemic therapy for progressive castration-naïve prostate cancer, in combination with an LHRH antagonist, with or without distant metastases

- Systemic therapy for castration-recurrent prostate cancer without distant metastases
- Subsequent systemic therapy, after prior enzalutamide/abiraterone or docetaxel therapy, for castration-recurrent prostate cancer with distant metastases

The organization does not state a preference for one first generation anti-androgen therapy over another. (NCCN, 2017)

- **Tarceva**

The FDA approved generic erlotinib, which is considered to be a therapeutic equivalent for all approved indications for Tarceva. Per the FDA, drug products are considered to be therapeutic equivalents only if they are pharmaceutical equivalents for which bioequivalence has been demonstrated, and they can be expected to have the same clinical effect and safety profile when administered to individuals under the conditions specified in the labeling.

FDA conducts post marketing drug and biologic safety surveillance. Types of information considered include reports made to the FDA Adverse Event Reporting System (FAERS) and medical literature. FDA evaluates each potential safety concern and may issue additional public communications as appropriate. There are no current reports challenging the safety of erlotinib. (FDA, 2019)

Erlotinib is considered to be a therapeutic alternative to Tarceva. Therapeutic alternatives can be expected to have similar outcomes and adverse reaction profiles and are determined from FDA approved product information, pharmaceutical compendia sources, clinical practice guidelines, and peer-reviewed published studies.

- **Targretin**

The FDA approved generic bexarotene, which is considered to be a therapeutic equivalent for all approved indications for Targretin. Per the FDA, drug products are considered to be therapeutic equivalents only if they are pharmaceutical equivalents for which bioequivalence has been demonstrated, and they can be expected to have the same clinical effect and safety profile when administered to individuals under the conditions specified in the labeling.

FDA conducts post marketing drug and biologic safety surveillance. Types of information considered include reports made to the FDA Adverse Event Reporting System (FAERS) and medical literature. FDA evaluates each potential safety concern and may issue additional public communications as appropriate. There are no current reports challenging the safety of bexarotene. (FDA, 2019)

Bexarotene is considered to be a therapeutic alternative to Targretin. Therapeutic alternatives can be expected to have similar outcomes and adverse reaction profiles and are determined from FDA approved product information, pharmaceutical compendia sources, clinical practice guidelines, and peer-reviewed published studies.

- **Temodar**

The FDA approved generic temozolomide, which is considered to be a therapeutic equivalent for all approved indications for Temodar. Per the FDA, drug products are considered to be therapeutic equivalents only if they are pharmaceutical equivalents for which bioequivalence has been demonstrated, and they can be expected to have the same clinical effect and safety profile when administered to individuals under the conditions specified in the labeling.

FDA conducts post marketing drug and biologic safety surveillance. Types of information considered include reports made to the FDA Adverse Event Reporting System (FAERS) and medical literature. FDA evaluates each potential safety concern and may issue additional public communications as appropriate. There are no current reports challenging the safety of temozolomide. (FDA, 2019)

Temozolomide is considered to be a therapeutic alternative to Temodar. Therapeutic alternatives can be expected to have similar outcomes and adverse reaction profiles and are determined from FDA approved

product information, pharmaceutical compendia sources, clinical practice guidelines, and peer-reviewed published studies.

- **Xeloda**

The FDA approved generic capecitabine, which is considered to be a therapeutic equivalent for all approved indications for Xeloda. Per the FDA, drug products are considered to be therapeutic equivalents only if they are pharmaceutical equivalents for which bioequivalence has been demonstrated, and they can be expected to have the same clinical effect and safety profile when administered to individuals under the conditions specified in the labeling.

FDA conducts post marketing drug and biologic safety surveillance. Types of information considered include reports made to the FDA Adverse Event Reporting System (FAERS) and medical literature. FDA evaluates each potential safety concern and may issue additional public communications as appropriate. There are no current reports challenging the safety of capecitabine. (FDA, 2019)

Capecitabine is considered to be a therapeutic alternative to Xeloda. Therapeutic alternatives can be expected to have similar outcomes and adverse reaction profiles and are determined from FDA approved product information, pharmaceutical compendia sources, clinical practice guidelines, and peer-reviewed published studies.

- **Xtandi**

In cases of castration-recurrent metastatic prostate cancer without visceral metastases, NCCN considers both enzalutamide (Xtandi) and abiraterone (Zytiga) as first-line therapies in individuals who are asymptomatic and who have had no prior chemotherapy. In the setting of metastatic castration resistant prostate cancer (CRPC) with visceral metastases, Xtandi is recommended as the first-line option. (NCCN, 2018)

In a provisional clinical opinion issued by American Society of Clinical Oncology (ASCO), chemotherapy naïve individuals who have failed first-line hormonal treatment who develop CRPC and have metastases should be offered Zytiga plus prednisone or Xtandi as second-line therapy. It is noted that both therapies have demonstrated significant improvement in radiographic progression-free survival and overall survival. (Virgo, 2017)

- **Yonsa**

NCCN makes the following recommendations for abiraterone acetate therapy:

- Systemic therapy for metastatic castration-resistant prostate cancer (CRPC), in combination with prednisone or methylprednisolone and an LHRH agonist or antagonist
- Systemic therapy for castration-sensitive prostate cancer, in combination with prednisone or methylprednisolone and an LHRH agonist or antagonist

(NCCN, 2018)

- **Zytiga**

The FDA approved generic abiraterone, which is considered to be a therapeutic equivalent for all approved indications for Zytiga. Per the FDA, drug products are considered to be therapeutic equivalents only if they are pharmaceutical equivalents for which bioequivalence has been demonstrated, and they can be expected to have the same clinical effect and safety profile when administered to individuals under the conditions specified in the labeling.

FDA conducts post marketing drug and biologic safety surveillance. Types of information considered include reports made to the FDA Adverse Event Reporting System (FAERS) and medical literature. FDA evaluates each potential safety concern and may issue additional public communications as appropriate. There are no current reports challenging the safety of abiraterone. (FDA, 2019)

Abiraterone is considered to be a therapeutic alternative to Zytiga. Therapeutic alternatives can be expected to have similar outcomes and adverse reaction profiles and are determined from FDA approved product

information, pharmaceutical compendia sources, clinical practice guidelines, and peer-reviewed published studies.

Coding/Billing Information

Oncology Medication Listing

Covered when medically necessary:

| Oncology Medication | Benefit Type: |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|
| Abemaciclib (Verzenio™) | Pharmacy |
| Abiraterone (Zytiga®) | Pharmacy |
| Abiraterone (Yonsa®) | Pharmacy |
| Acalabrutinib (Calquence®) | Pharmacy |
| Afatinib (Gilotrif™) | Pharmacy |
| Alectinib (Alecensa®) | Pharmacy |
| Alpelisib (Piqray®) | Pharmacy |
| Amivantamab-vmjw (Rybrevant) <i>Note: if coverage of Rybrevant as a medical benefit, refer to the Medical Benefit table</i> | Pharmacy |
| Anakinra (Kineret®) | Pharmacy |
| Apalutamide (Erleada™) | Pharmacy |
| Asparaginase Erwinia chrysanthemi (Erwinaze®) <i>Note: if coverage of Erwinaze as a medical benefit, refer to the Medical Benefit table</i> | Pharmacy |
| Asparaginase erwinia-rywn (Rylaze) <i>Note: if coverage of Rylaze as a medical benefit, refer to the Medical Benefit table</i> | Pharmacy |
| Axitinib (Inlyta®) | Pharmacy |
| Avapritinib (Ayvakit™) | Pharmacy |
| Azacitidine (Onureg®) | Pharmacy |
| Bexarotene (Targretin®) | Pharmacy |
| Binimetinib (Mektovi®) | Pharmacy |
| Bosutinib (Bosulif®) | Pharmacy |
| Brigatinib (Alunbrig™) | Pharmacy |
| Cabozantinib (Cabometyx™) | Pharmacy |
| Cabozantinib (Cometriq™) | Pharmacy |
| Capecitabine (Xeloda®) | Pharmacy |
| Capmatinib (Tabrecta™) | Pharmacy |
| Ceritinib (Zykadia™) | Pharmacy |
| Cobimetinib (Cotellic) | Pharmacy |
| Crizotinib (Xalkori®) | Pharmacy |
| Dacomitinib (Vizimpro®) | Pharmacy |
| Dabrafenib (Tafinlar®) | Pharmacy |
| Darolutamide (Nubeqa®) | Pharmacy |
| Dasatinib (Sprycel®) | Pharmacy |
| Decitabine and cedazuridine (Inqovi®) | Pharmacy |
| Degarelix (Firmagon®)* | Pharmacy |
| Dostarlimab-gxly (Jemperli) <i>Note: if coverage of Jemperli as a medical benefit, refer to the Medical Benefit table</i> | Pharmacy |
| Duvelisib (Copiktra™) | Pharmacy |
| Enasidenib (Idhifa®) | Pharmacy |
| Encorafenib (Braftovi™) | Pharmacy |
| Entrectinib (Rozlytrek™) | Pharmacy |

| Oncology Medication | Benefit Type: |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|
| Enzalutamide (Xtandi®) | Pharmacy |
| Erdafitinib (Balversa™) | Pharmacy |
| Erlotinib (Tarceva®) | Pharmacy |
| Everolimus (Afinitor®, Afinitor® Disperz) | Pharmacy |
| Fam-trastuzumab deruxtecan-nxki (Enhertu®) <i>Note: if coverage of Enhertu as a medical benefit, refer to the Medical Benefit table</i> | Pharmacy |
| Fedratinib dihydrochloride (Inrebic®) | Pharmacy |
| Gefitinib (Iressa®) | Pharmacy |
| Gilteritinib (Xospata®) | Pharmacy |
| Glasdegib maleate (Daurismo™) | Pharmacy |
| Goserelin (Zoladex®)* | Pharmacy |
| Ibrutinib (Imbruvica®) | Pharmacy |
| Idelalisib (Zydelig®) | Pharmacy |
| Imatinib (Gleevec®) | Pharmacy |
| Infigratinib (Truseltiq) | Pharmacy |
| Ipilimumab (Yervoy®) <i>Note: if coverage of Yervoy as a medical benefit, refer to the Medical Benefit table</i> | Pharmacy |
| Ivosidenib (Tibsovo®) | Pharmacy |
| Interferon gamma-1b (Actimmune®) | Pharmacy |
| Ixazomib (Ninlaro®) | Pharmacy |
| Lapatinib (Tykerb®) | Pharmacy |
| Larotrectinib sulfate (Vitrakvi®) | Pharmacy |
| Lenalidomide (Revlimid®) | Pharmacy |
| Lenvatinib (Lenvima™) | Pharmacy |
| Letrozole; ribociclib (Kisqali® Femara® Co-Pack) | Pharmacy |
| Leuprolide (Lupron Depot®, Eligard®)* <i>Note: if coverage of Leuprolide as a medical benefit, refer to the Medical Benefit table</i> | Pharmacy |
| Loncastuximab tesirine-lpyl (Zynlonta) <i>Note: if coverage of Zynlonta as a medical benefit, refer to the Medical Benefit table</i> | Pharmacy |
| Lorlatinib (Lorbrena®) | Pharmacy |
| Margetuximab-cmkb (Margenza) <i>Note: if coverage of Margenza as a medical benefit, refer to the Medical Benefit table</i> | Pharmacy |
| Midostaurin (Rydapt®) | Pharmacy |
| Neratinib (Nerlynx®) | Pharmacy |
| Nilotinib (Tasigna®) | Pharmacy |
| Nilutamide (Nilandron®) | Pharmacy |
| Niraparib tosylate (Zejula™) | Pharmacy |
| Nivolumab (Opdivo®) <i>Note: if coverage of Opdivo as a medical benefit, refer to the Medical Benefit table</i> | Pharmacy |
| Olaparib (Lynparza™) | Pharmacy |
| Osimertinib (Tagrisso™) | Pharmacy |
| Palbociclib (Ibrance®) | Pharmacy |
| Panobinostat (Farydak®) | Pharmacy |
| Pazopanib (Votrient®) | Pharmacy |
| Peginterferon alfa-2a (PegaSys®) | Pharmacy |
| Peginterferon alfa-2b (PegIntron®) | Pharmacy |

| Oncology Medication | Benefit Type: |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|
| Peginterferon alfa-2b (Sylatron™) | Pharmacy |
| Pemigatinib (Pemazyre™) | Pharmacy |
| Pertuzumab, trastuzumab, and hyaluronidase-zzxf (Phesgo™) <i>Note: If coverage of Phesgo as a medical benefit, refer to the Medical Benefit table</i> | Pharmacy |
| Pexidartinib (Turalio™) | Pharmacy |
| Pomalidomide (Pomalyst®) | Pharmacy |
| Ponatinib (Iclusig®) | Pharmacy |
| Pralsetinib (Gavreto™) | Pharmacy |
| Regorafenib (Stivarga®) | Pharmacy |
| Relugolix (Orgovyx™) | Pharmacy |
| Ribociclib (Kisqali®) | Pharmacy |
| Ripretinib (Qinlock™) | Pharmacy |
| Rucaparib (Rubraca™) | Pharmacy |
| Ruxolitinib (Jakafi®) | Pharmacy |
| Selinexor (Xpovio™) | Pharmacy |
| Selpercatinib (Retevmo™) | Pharmacy |
| Sonidegib (Odomzo®) | Pharmacy |
| Sorafenib (Nexavar®) | Pharmacy |
| Sotorasib (Lumakras) | Pharmacy |
| Sunitinib (Sutent®) | Pharmacy |
| Talazoparib (Talzenna®) | Pharmacy |
| Tazemetostat (Tazverik™) | Pharmacy |
| Telotristat (Xermelo™) | Pharmacy |
| Temozolomide (Temodar®) | Pharmacy |
| Tepotinib (Tepmetko®) | Pharmacy |
| Thalidomide (Thalomid®) | Pharmacy |
| Tivozanib HCl (Fotivda) | Pharmacy |
| Topotecan (Hycamtin®) | Pharmacy |
| Trametinib (Mekinist™) | Pharmacy |
| Tretinoin (Vesanoid®) | Pharmacy |
| Trifluridine and tipiracil (Lonsurf®) | Pharmacy |
| Triptorelin pamoate (Trelstar®) <i>Note: if coverage of Triptorelin pamoate as a medical benefit, refer to the Medical Benefit table</i> | Pharmacy |
| Tucatinib (Tukysa™) | Pharmacy |
| Umbralisib tosylate (Ukoniq™) | Pharmacy |
| Vandetanib (Caprelsa®) | Pharmacy |
| Vemurafenib (Zelboraf®) | Pharmacy |
| Venetoclax (Venclexta™) | Pharmacy |
| Vismodegib (Erivedge™) | Pharmacy |
| Vorinostat (Zolinza®) | Pharmacy |
| Zanubrutinib (Brukinsa™) | Pharmacy |

* When covered by pharmacy benefit

Note: These medications are covered under pharmacy benefit plans. Certain prescription drugs require an authorization for coverage to ensure that appropriate treatment regimens are followed. Medical drug coding and diagnosis codes, however, are generally not required for pharmacy claims submissions; therefore, coding information is not provided.

Covered when medically necessary:

Note:

- 1) This list of codes may not be all-inclusive.
- 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

| Oncology Medication | Benefit Type: | HCPCS Code: | Description |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| Ado-trastuzumab emtansine (Kadcyla®) | Medical | J9354 | Injection, ado-trastuzumab emtansine, 1mg |
| Amivantamab-vmjw (Rybrevant) <i>Note: if coverage of Rybrevant as a pharmacy benefit, refer to the Pharmacy Benefit table</i> | Medical | C9399 J3490 J3590 J9999 | Unclassified drugs or biologicals Unclassified drugs Unclassified biologics Not otherwise classified, antineoplastic drugs |
| Aldesleukin (Proleukin®) | Medical | J9015 | Injection, aldesleukin, per single use vial |
| Arsenic trioxide (Trisenox®) | Medical | J9017 | Injection, arsenic trioxide, 1 mg |
| Asparaginase Erwinia chrysanthemi (Erwinaze®) <i>Note: if coverage of Erwinaze as a pharmacy benefit, refer to the Pharmacy Benefit table</i> | Medical | J9019 | Injection, asparaginase (Erwinaze) 1,000 IU |
| Asparaginase erwinia-rywn (Rylaze) <i>Note: if coverage of Rylaze as a pharmacy benefit, refer to the Pharmacy Benefit table</i> | Medical | C9399 J3490 J9999 | Unclassified drugs or biologicals Unclassified drugs Not otherwise classified, antineoplastic drugs |
| Atezolizumab (Tecentriq®) | Medical | J9022 | Injection, atezolizumab, 10 mg |
| Avelumab (Bavencio®) | Medical | J9023 | Injection, avelumab, 10 mg |
| Azacitidine | Medical | J9025 | Injection, azacitidine, 1 mg |
| Belantamab mafodotin-blmp (Blenrep™) | Medical | C9069 J9037 | Injection, belantamab mafodotin-blmp, 0.5 mg (Code deleted 03/31/2021) Injection, belantamab mafodotin-blmp, 0.5 mg |
| Belinostat (Beleodaq®) | Medical | J9032 | Injection, Belinostat, 10 mg |
| Bendamustine (Belrapzo) | Medical | J9036 | Injection, bendamustine hydrochloride, (belrapzo/bendamustine), 1 mg |
| Bendamustine (Bendeka™) | Medical | J9034 | Injection, bendamustine HCL (bendeka), 1 mg |
| Bendamustine (Treanda®) | Medical | J9033 | Injection, bendamustine HCL (Treanda), 1 mg |
| Bevacizumab (Avastin®) | Medical | J9035 | Injection, bevacizumab, 10 mg |
| Bevacizumab-awwb (Mvasi™) | Medical | Q5107 | Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg |
| Bevacizumab-bvzr (Zirabev™) | Medical | Q5118 | Injection, bevacizumab-bvzr, biosimilar, (zirabev), 10 mg |
| Bleomycin sulfate | Medical | J9040 | Injection, bleomycin sulfate, 15 units |
| Blinatumomab (Blincyto®) | Medical | J9039 | Injection, blinatumomab 1 microgram |
| Bortezomib (Velcade®) | Medical | J9041 | Injection, bortezomib (velcade), 0.1 mg |
| Bortezomib | Medical | J9044 | Injection, bortezomib, not otherwise specified, 0.1 mg |
| Brentuximab Vedotin (Adcetris®) | Medical | J9042 | Injection, Brentuximab Vedotin, 1 mg |
| Cabazitaxel (Jevtana®) | Medical | J9043 | Injection, cabazitaxel, 1 mg |
| Calaspargase pegol-mknl (Asparlas™) | Medical | J9118 | Injection, calaspargase pegol-mknl, 10 units |
| Carboplatin | Medical | J9045 | Injection, carboplatin, 50 mg |
| Carfilzomib (Kyprolis®) | Medical | J9047 | Injection, carfilzomib, 1 mg |
| Cemiplimab-rwlc (Libtayo®) | Medical | J9119 | Injection, cemiplimab-rwlc, 1 mg |
| Cetuximab (Erbix®) | Medical | J9055 | Injection, cetuximab, 10 mg |

| Oncology Medication | Benefit Type: | HCPCS Code: | Description |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-------------------------|-----------------------------------------------------------------------------------|
| Cisplatin | Medical | J9060 | Injection, cisplatin, powder or solution, 10 mg |
| Cladribine | Medical | J9065 | Injection, cladribine, per 1 mg |
| Clofarabine (Clolar®) | Medical | J9027 | Injection, clofarabine, 1 mg |
| Copanlisib (Aliqopa™) | Medical | J9057 | Injection, copanlisib, 1 mg |
| Cytarabine liposome/PF (Depocyt®) | Medical | J9098 | Injection, cytarabine liposome, 10 mg |
| Cytarabine/PF | Medical | J9100 | Injection, cytarabine, 100 mg |
| Dacarbazine | Medical | J9130 | Dacarbazine, 100 mg |
| Dactinomycin (Cosmegen®) | Medical | J9120 | Injection, dactinomycin, 0.5 mg |
| Daratumumab (Darzalex™) | Medical | J9145 | Injection, daratumumab, 10 mg |
| Daratumumab and hyaluronidase-fihj (Darzalex Faspro™) | Medical | C9062 | Injection, daratumumab 10 mg and hyaluronidase-fihj (Code deleted 12/31/2020) |
| Daratumumab and hyaluronidase-fihj (Darzalex Faspro™) | Medical | J9144 | Injection, daratumumab 10 mg and hyaluronidase-fihj |
| Daunorubicin HCl | Medical | J9150 | Injection, daunorubicin, 10 mg |
| Daunorubicin and cytarabine (Vyxeos®) | Medical | J9153 | Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine |
| Decitabine (Dacogen®) | Medical | J0894 | Injection, decitabine, 1 mg |
| Degarelix (Firmagon®)** | Medical | J9155 | Injection, degarelix, 1 mg |
| Docetaxel (Taxotere®) | Medical | J9171 | Injection, docetaxel, 1 mg |
| Dostarlimab-gxly (Jemperli) <i>Note: if coverage of Jemperli as a pharmacy benefit, refer to the Pharmacy Benefit table</i> | Medical | C9399 J3490 J3590 | Unclassified drugs or biologicals Unclassified drugs Unclassified biologics |
| Doxorubicin HCL | Medical | J9000 | doxorubicin hydrochloride, 10 mg |
| Doxorubicin HCL PEG-Liposomal (Doxil®) | Medical | Q2050 | Injection, doxorubicin hydrochloride, liposomal, not otherwise specified, 10 mg |
| Durvalumab (Imfinzi®) | Medical | J9173 | Injection, durvalumab, 10 mg |
| Elotuzumab (Empliciti®) | Medical | J9176 | Injection, elotuzumab, 1 mg |
| Enfortumab vedotin-ejfv (Padcev™) | Medical | J9177 | Injection, enfortumab vedotin-ejfv, 0.25 mg |
| Epirubicin HCl (Ellence®) | Medical | J9178 | Injection, epirubicin HCl, 2 mg |
| Eribulin mesylate (Halaven®) | Medical | J9179 | Injection, eribulin mesylate, 0.1 mg |
| Etoposide phosphate (Etopophos®) | Medical | J9181 | Injection, etoposide, 10 mg |
| Fam-trastuzumab deruxtecan-nxki (Enhertu®) <i>Note: if coverage of Enhertu as a pharmacy benefit, refer to the Pharmacy Benefit table</i> | Medical | J9358 | Injection, fam-trastuzumab deruxtecan-nxki, 1 mg |
| Floxuridine | Medical | J9200 | Injection, floxuridine, 500 mg |
| Fludarabine phosphate | Medical | J9185 | Injection, fludarabine phosphate, 50 mg |
| Fluorouracil | Medical | J9190 | Injection, fluorouracil, 500 mg |
| Fulvestrant (Faslodex®) | Medical | J9395 | Injection, fulvestrant, 25 mg |
| Gemcitabine HCl | Medical | J9201 | Injection, gemcitabine hydrochloride, not otherwise specified, 200 mg |
| Gemcitabine (Infugem™) | Medical | J9198 | Injection, gemcitabine hydrochloride, (Infugem), 100 mg |
| Gemtuzumab ozogamicin (Mylotarg™) | Medical | J9203 | Injection, gemtuzumab ozogamicin, 0.1 mg |

| Oncology Medication | Benefit Type: | HCPCS Code: | Description |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| Goserelin (Zoladex®)** | Medical | J9202 | Goserelin acetate implant, per 3.6 mg |
| Histrelin (Vantas®) | Medical | J9225 | Histrelin implant (Vantas), 50 mg |
| Idarubicin (Idamycin PFS®) | Medical | J9211 | Injection, idarubicin hydrochloride, 5 mg |
| Ifosfamide (Ifex) | Medical | J9208 | Injection, ifosfamide, 1 gram |
| Inotuzumab ozogamicin (Besponsa™) | Medical | J9229 | Injection, inotuzumab ozogamicin, 0.1 mg |
| Interferon alfa-2b (Intron®A) | Medical | J9214 | Injection, interferon alfa-2b, recombinant, 1 million units |
| Ipilimumab (Yervoy®) <i>Note: if coverage of Yervoy as a pharmacy benefit, refer to the Pharmacy Benefit table</i> | Medical | J9228 | Injection, ipilimumab, 1 mg |
| Irinotecan (Camptosar®) | Medical | J9206 | Injection, irinotecan, 20 mg |
| Irinotecan liposome (Onivyde®) | Medical | J9205 | Injection, irinotecan liposome, 1 mg |
| Isatuximab-irfc (Sarclisa®) | Medical | J9227 | Injection, isatuximab-irfc, 10 mg |
| Ixabepilone (Ixempra®) | Medical | J9207 | Injection, ixabepilone, 1 mg |
| Lanreotide (Somatuline Depot®) | Medical | J1930 | Injection, lanreotide, 1 mg |
| Leuprolide (Lupron Depot®, Eligard®) <i>Note: if coverage of Leuprolide as a pharmacy benefit, refer to the Pharmacy Benefit table</i> | Medical | J1950 | Injection, leuprolide acetate (for depot suspension), per 3.75 mg |
| Leuprolide (Lupron Depot®) | Medical | J9217 | Leuprolide acetate (for depot suspension), 7.5 mg |
| Levoleucovorin (Fusilev®) | Medical | J0641 | Injection, levoleucovorin, 0.5 mg |
| Levoleucovorin (Khaphzory™) | Medical | J0642 | Injection, levoleucovorin (khaphzory), 0.5 mg |
| Loncastuximab tesirine-lpyl (Zynlonta) <i>Note: if coverage of loncastuximab-tesirine-lpyl as a pharmacy benefit, refer to the Pharmacy Benefit table</i> | Medical | C9399 J3490 J3590 | Unclassified drugs or biologicals Unclassified drugs Unclassified biologics |
| Lurbinectedin (Zepzelca™) | Medical | J9223 | Injection, lurbinectedin, 0.1 mg |
| Margetuximab-cmkb (Margenza) <i>Note: if coverage of Margenza as a pharmacy benefit, refer to the Pharmacy Benefit table</i> | Medical | J9353 | Injection, margetuximab-cmkb, 5 mg |
| Mechlorethamine (Mustargen®) | Medical | J9230 | Injection, mechlorethamine hydrochloride, (nitrogen mustard), 10 mg |
| Melphalan (Alkeran® Evomela®) | Medical | J9245 | Injection, melphalan hydrochloride, 50 mg |
| Melphalan flufenamide HCl (Pepaxto) | Medical | C9080 J3490 J9999 | Injection, melphalan flufenamide hydrochloride, 1 mg Unclassified drugs Not otherwise classified, antineoplastic drugs |
| Mitomycin | Medical | J9280 | Injection, mitomycin, 5 mg |
| Mitomycin ureteral gel (Jelmyto) | Medical | J9281 | Mitomycin pyelocalyceal instillation, 1 mg |
| Mitoxantrone HCl | Medical | J9293 | Injection, mitoxantrone hydrochloride, per 5 mg |
| Mogamulizumab-kpkc (Poteligeo®) | Medical | J9204 | Injection, mogamulizumab-kpkc, 1 mg |
| Moxetumomab pasudotox-tdfk (Lumoxiti™) | Medical | J9313 | Injection, moxetumomab pasudotox-tdfk, 0.01 mg |

| Oncology Medication | Benefit Type: | HCPCS Code: | Description |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Naxitamab-ggqk (Danyelza®) | Medical | J9348 | Injection, naxitamab-ggqk, 1 mg |
| Necitumumab (Portrazza™) | Medical | J9295 | Injection, necitumumab, 1 mg |
| Nelarabine (Arranon®) | Medical | J9261 | Injection, nelarabine, 50 mg |
| Nivolumab (Opdivo®) <i>Note: if coverage of Opdivo as a pharmacy benefit, refer to the Pharmacy Benefit table</i> | Medical | J9299 | Injection, nivolumab, 1 mg |
| Octreotide injectable suspension (Sandostatin LAR Depot) | Medical | J2353 | Injection, octreotide, depot form for intramuscular injection, 1 mg |
| Obinutuzumab (Gazyva®) | Medical | J9301 | Injection, obinutuzumab, 10 mg |
| Ofatumumab (Arzerra®) | Medical | J9302 | Injection, ofatumumab, 10 mg |
| Omacetaxine mepesuccinate (Synribo®) | Medical | J9262 | Injection, omacetaxine mepesuccinate, 0.01 mg |
| Oxaliplatin | Medical | J9263 | Injection, oxaliplatin, 0.5 mg |
| Paclitaxel | Medical | J9267 | Injection, paclitaxel, 1 mg |
| Paclitaxel protein-bound particles for injectable suspension, (Abraxane®) | Medical | J9264 | Injection, paclitaxel protein-bound particles, 1 mg |
| Panitumumab (Vectibix®) | Medical | J9303 | Injection, panitumumab, 10 mg |
| Pegaspargase (Oncaspar®) | Medical | J9266 | Injection, pegaspargase, per single dose vial |
| Pembrolizumab (Keytruda®) | Medical | J9271 | Injection, Pembrolizumab, 1 mg |
| Pemetrexed (Alimta®) | Medical | J9305 | Injection, pemetrexed, 10 mg |
| Pentostatin (Nipent™) | Medical | J9268 | Injection, pentostatin, 10 mg |
| Pertuzumab (Perjeta®) | Medical | J9306 | Injection, pertuzumab, 1 mg |
| Pertuzumab, trastuzumab, and hyaluronidase-zzxf (Phesgo™) <i>Note: If coverage of Phesgo as a pharmacy benefit, refer to the Pharmacy Benefit table</i> | Medical | J9316 | Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg |
| Polatuzumab vedotin (Polivy™) | Medical | J9309 | Injection, polatuzumab vedotin-piiq, 1 mg |
| Pralatrexate (Folotyn®) | Medical | J9307 | Injection, pralatrexate, 1 mg |
| Ramucirumab (Cyramza®) | Medical | J9308 | Injection, ramucirumab, 5 mg |
| Rituximab (Rituxan®) | Medical | J9312 | Injection, rituximab, 10 mg |
| Rituximab-abbs (Truxima®) | Medical | Q5115 | Injection, rituximab-abbs, biosimilar, 10 mg |
| Rituximab-arxx (Riabni™) | Medical | Q5123 | Injection, rituximab-arxx, biosimilar, (riabni), 10 mg |
| Rituximab and hyaluronidase human (Rituxan Hycela™) | Medical | J9311 | Injection, rituximab 10 mg and hyaluronidase |
| Rituximab-pvvr (Ruxience™) | Medical | Q5119 | Injection, rituximab-pvvr, biosimilar, (ruxience), 10 mg |
| Romidepsin | Medical | J9314 | Injection, romidepsin, non-lyophilized (e.g. liquid), 0.1 mg |
| Romidepsin (Istodax®) | Medical | J9315 | Injection, romidepsin, 1 mg |
| Sacituzumab govitecan-hziy (Trodelvy™) | Medical | C9066 J9317 | Injection, sacituzumab govitecan-hziy, 2.5 mg (Code deleted 12/31/2020) Injection, sacituzumab govitecan-hziy, 2.5 mg |
| Siltuximab (Sylvant®) | Medical | J2860 | Injection, siltuximab, 10 mg |
| Sipuleucel-T (Provenge®) | Medical | Q2043 | Sipuleucel-t, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion |

| Oncology Medication | Benefit Type: | HCPCS Code: | Description |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------|--------------------------------------------------------------------------------------------------|
| Streptozocin (Zanosar®) | Medical | J9320 | Injection, streptozocin, 1 gram |
| Tagraxofusp-erzs (Elzonris®) | Medical | J9269 | Injection, Tagraxofusp-erzs, 10 micrograms |
| Tafasitamab-cxix (Monjuvi) | Medical | C9070 J9349 | Injection, tafasitamab-cxix, 2 mg (Code deleted 03/31/2021) Injection, tafasitamab-cxix, 2 mg |
| Talimogene (Imlygic®) | Medical | J9325 | Injection, talimogene laherparepvec, per 1 million plaque forming units |
| Temozolomide (Temodar®) | Medical | J9328 | Injection, temozolomide, 1 mg |
| Temsirolimus (Torisel®) | Medical | J9330 | Injection, temsirolimus, 1 mg |
| Teniposide | Medical | Q2017 | Injection, teniposide, 50 mg |
| Thiotepa | Medical | J9340 | Injection, thiotepa, 15 mg |
| Tocilizumab (Actemra®) | Medical | J3262 | Injection, tocilizumab, 1 mg |
| Topotecan (Hycamtin®) | Medical | J9351 | Injection, topotecan, 0.1 mg |
| Trabectedin (Yondelis®) | Medical | J9352 | Injection, trabectedin, 0.1 mg |
| Trastuzumab (Herceptin®) | Medical | J9355 | Injection, trastuzumab, 10 mg |
| Trastuzumab-anns (Kanjinti) | Medical | Q5117 | Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg |
| Trastuzumab-dkst (Ogivri) | Medical | Q5114 | Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg |
| Trastuzumab-dttb (Ontruzant) | Medical | Q5112 | Injection, trastuzumab-dttb, biosimilar, (ontruzant), 10 mg |
| Trastuzumab-pkrb (Herzuma®) | Medical | Q5113 | Injection, trastuzumab-pkrb, biosimilar, (herzuma), 10 mg |
| Trastuzumab-qyyp (Trazimera™) | Medical | Q5116 | Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg |
| Trastuzumab and Hyaluronidase-oysk (Herceptin Hylecta™) | Medical | J9356 | Injection, trastuzumab, 10 mg and Hyaluronidase-oysk |
| Triptorelin pamoate (Trelstar®) <i>Note: if coverage of Triptorelin pamoate as a pharmacy benefit, refer to the Pharmacy Benefit table</i> | Medical | J3315 | Injection, triptorelin pamoate, 3.75 mg |
| Vinblastine HCl | Medical | J9360 | Injection, vinblastine sulfate, 1 mg |
| Vincristine (Vincasar PFS®) | Medical | J9370 | Vincristine sulfate, 1 mg |
| vincristine sulfate LIPOSOME injection (Marqibo®) | Medical | J9371 | Injection, vincristine sulfate liposome, 1mg |
| Vinorelbine (Navelbine®) | Medical | J9390 | Injection, vinorelbine tartrate, 10 mg |
| Ziv-aflibercept (Zaltrap®) | Medical | J9400 | Injection, Ziv-aflibercept, 1 mg |

** When covered by medical benefit, pre-certification is not required

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