Pharmacy Management Drug Policy

SUBJECT: Immune Checkpoint Inhibitor Clinical Review Prior Authorization (CRPA) Policy
POLICY NUMBER: PHARMACY-96
EFFECTIVE DATE: 12/2020
LAST REVIEW DATE:11/20/2026

If the member's subscriber contract excludes coverage for a specific service or prescription drug, it is not covered under that contract. In such cases, medical or drug policy criteria are not applied. This drug policy applies to the following line/s of business:

Policy Application

Category:	☒ Commercial Group (e.g., EPO, HMO, POS, PPO)	☒ Medicare Advantage
	☒ On Exchange Qualified Health Plans (QHP)	☐ Medicare Part D
	☒ Off Exchange Direct Pay	☒ Essential Plan (EP)
	☒ Medicaid & Health and Recovery Plans (MMC/HARP)	☒ Child Health Plus (CHP)
	☐ Federal Employee Program (FEP)	☐ Ancillary Services
	☒ Dual Eligible Special Needs Plan (D-SNP)	

DESCRIPTION:

This policy contains the coverage criteria for oncologic Immune Checkpoint Inhibitors. The Immune Checkpoint Inhibitors include programmed cell death 1 (PD-1) inhibitors, programmed death-ligand 1 (PD-L1) inhibitors, cytotoxic T-lymphocyte-associated protein 4 (CTLA-4) inhibitors, and lymphocyte-'activation gene 3 (LAG-3) blockers.

Keytruda (pembrolizumab), Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph), Opdivo (nivolumab), Opdivo Qvantig (nivolumab and hyaluronidase- nvhy), Libtayo (cemiplimab), Loqtorzi (toripalimab-tpzi), Jemperli (dostarlimab-gxly), Tevimbra (tislelizumab-jsgr) and Zynyz (retifanlimab-dlwr) are all PD-1 blocking antibodies. PD-L1 blocking antibodies include Tecentriq (atezolizumab), Tecentriq Hybreza (atezolizumab and hyaluronidase- tqjs), Bavencio (avelumab), Imfinzi (durvalumab) and Unloxcyt (cosibelimab). Yervoy (ipilimumab) and Imjudo (tremelimumab-actl) are CTLA-4 blocking antibodies, CTLA-4 blocking antibodies often used in combination with other Immune Checkpoint Inhibitors. Opdualag (nivolumab/relatlimab-rmbw) is fixed-dose combination product containing nivolumab (a PD-1 blocker) and relatlimab-rmbw (a novel LAG-3 blocker).

Immune checkpoint inhibitors work by blocking certain receptors (either PD-1 [present on T cells] or CTLA-4 [present on T cells]) or ligands (PD-L1 [present on tumor cells]) resulting in an enhanced antitumor immune response.

The Immune Checkpoint Inhibitors Clinical Review Prior-Authorization (CRPA) process is designed to ensure that newly approved (FDA) prescription drugs are used appropriately in cases where a drug poses potential efficacy, quality, toxicity, or utilization concerns for the members and the Health Plan. In addition, this policy may be used for medications that have significant concerns about safety or inappropriate use, but do not warrant a stand-alone policy. The Pharmacy Management clinical team reviews the Immune Checkpoint Inhibitors falling into these categories under the process of Clinical Review Prior Authorization (CRPA). A Letter of Medical Necessity (LOMN), Exception Form, or Prior Authorization Form completion is required for consideration of drug coverage under this policy.

Prior Authorization criteria listed in this policy is based on FDA labeled indication or NCCN level of evidence 1 or 2A. For requests that do not meet the policy criteria defined below, please refer to the Off-Label Use of FDA Approved Drugs policy.

POLICY GUIDELINES:

1. This policy is subject to frequent revisions as new medications come onto the market. Some drugs will require prior authorization prior to approve language being added to the policy.
2. Supportive documentation of previous drug use must be submitted for any criteria which require trial of a preferred agent if the preferred drug is not found in claims history.
3. Clinical documentation must be submitted for each request (initial and recertification). Supporting clinical documentation includes but is not limited to progress notes documenting previous treatments/treatment history, laboratory test results, genetic testing/biomarker test results, and imagining.
4. Dose and frequency should be consistent with FDA labeling, NCCN Compendia, or Indication Specific Peer-Reviewed Literature. When the dose and/or frequency is requested in excess of established parameters, the request may be subject to an off-label review for medical necessity.
5. Not all contracts cover all Medical Infusible drugs. Refer to specific contract/benefit plan language for exclusions of Injectable Medications.
6. For contracts where Insurance Law § 4903(c-1), and Public Health Law § 4903(3-a) are applicable, if trial of preferred drug(s) is the only criterion that is not met for a given condition, and one of the following circumstances can be substantiated by the requesting provider, then trial of the preferred drug(s) will not be required.
   - The required prescription drug(s) is (are) contraindicated or will likely cause an adverse reaction or physical or mental harm to the member;
   - The required prescription drug is expected to be ineffective based on the known clinical history and conditions and concurrent drug regimen;
   - The required prescription drug(s) was (were) previously tried while under the current or a previous health plan, or another prescription drug or drugs in the same pharmacologic class or with the same mechanism of action was (were) previously tried and such prescription drug(s) was (were) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
   - The required prescription drug(s) is (are) not in the patient's best interest because it will likely cause a significant barrier to adherence to or compliance with the plan of care, will likely worsen a comorbid condition, or will likely decrease the ability to achieve or maintain reasonable functional ability in performing daily activities;
   - The individual is stable on the requested prescription drug. The medical profile of the individual (age, disease state, comorbidities), along with the rational for deeming stability as it relates to standard medical practice and evidence-based practice protocols for the disease state will be taken into consideration.
   - The above criteria are not applicable to requests for brand name medications that have an AB rated generic. We can require a trial of an AB-rated generic equivalent prior to providing coverage for the equivalent brand name prescription drug.
7. Unless otherwise stated below within the Drug Specific Criteria (TABLE 4), approval time periods are listed in TABLE 1 below
   a. Continued approval at time of recertification will require documentation that the drug is providing ongoing benefit to the patient in terms of improvement or stability in disease state or condition. Such documentation may include progress notes, imaging or laboratory findings, and other objective or subjective measures of benefit which support that continued use of the requested product is medically necessary. Also, ongoing use of the requested product must continue to reflect the current policy's preferred formulary [Recertification reviews may result in the requirement to try more cost-effective treatment alternatives as they become available (i.e., generics, biosimilars, or other guideline-supported treatment options)]

and the requested dose must continue to meet FDA approved or off-label/guideline supported dosing

b. Recertifications will be evaluated for the regimen that is currently being prescribed (monotherapy, combination therapy, etc.). If this differs from the initial review, the request will be reviewed based on the level of evidence that is available for the current regimen.

8. This policy does not apply to Medicare Part D and D-SNP pharmacy benefits. The drugs in this policy may apply to all other lines of business including Medicare Advantage.
9. For members with Medicare Advantage, medications with a National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) will be covered pursuant to the criteria outlined by the NCD and/or LCD. NCDs/LCDs for applicable medications can be found on the CMS website at https://www.cms.gov/medicare-coverage-database/search.aspx. Indications that have not been addressed by the applicable medication's LCD/NCD will be covered in accordance with criteria determined by the Health Plan (which may include review per the Health Plan's Off- Label Use of FDA Approved Drugs policy). Step therapy requirements may be imposed in addition to LCD/NCD requirements.
10. Unless otherwise explicitly stated in the NCCN compendia, the use of an immune checkpoint inhibitor therapy following disease progression on prior immune checkpoint inhibitor therapy is considered experimental and investigational and will be subject to an off-label review
11. Unless otherwise indicated within drug specific criteria, the drugs listed in this policy are administered by a healthcare professional and therefore are covered under the medical benefit.
12. Preferred product requirements do not apply to Medicare Advantage plans
13. All requests will be reviewed to ensure they are being used for an appropriate indication and may be subject to an off-label review in accordance with our Off-Label Use of FDA Approved Drugs Policy (Pharmacy-32). This includes any request that is made for drug(s) that was (were)previously tried (including in the same pharmacologic class or with the same mechanism of action) and such drug(s) was (were) discontinued due to a lack of efficacy.
14. All utilization management requirements outlined in this policy are compliant with applicable New York State insurance laws and regulations. Policies will be reviewed and updated as necessary to ensure ongoing compliance with all state and federally mandated coverage requirements.
15. Manufacturers may either discontinue participation in, or may not participate in, the Medicaid Drug Rebate Program (MDRP). Under New York State Medicaid requirements, physician-administered drugs must be produced by manufacturers that participate in the MDRP. Products made by manufacturers that do not participate in the MDRP will not be covered under Medicaid Managed Care/HARP lines of business. Drug coverage will not be available for any product from a non-participating manufacturer. For a complete list of New/Reinstated & Terminated Labelers please visit: https://www.medicaid.gov/medicaid/prescriptiondrugs/medicaid-drug-rebate-program/newreinstated-terminated-labeler-information/index.html
16. Approval timeframes may be extended to align authorization periods for drugs administered as part of a multidrug regimen, including when regimen components are administered across different benefits. This provision does not apply when the approval timeframe reflects a drug-specific limitation on duration of therapy.

TABLE 1. APPROVAL TIME PERIODS:

Line of Business	Initial approval	Continued approval
Commercial, Exchange, and SafetyNet (Medicaid, HARP, CHP, Essential Plan)	6 months	6 months
Medicare Part B	6 months	6 months

TABLE 2. IMMUNE CHECKPOINT INHIBITOR DRUGS INCLUDED IN THIS POLICY:

Drug name (generic name)	HCPCS
Bavencio (avelumab)	J9023
Imfinzi (durvalumab)	J9173
Imjudo (tremelimumab-actl)	J9347
Jemperli (dostarlimab-gxly)	J9272
Keytruda (pembrolizumab)	J9271
Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph)	J9277
Libtayo (cemiplimab-rwlc)	J9119
Loqtorzi (toripalimab-tpzi)	J3263
Opdivo (nivolumab)	J9299
Opdivo Qvantig (nivolumab and hyaluronidase-nvhy)	J9289
Opdualag (nivolumab/relatlimab-rmbw)	J9298
Tecentriq (atezolizumab)	J9022
Tecentriq Hybreza (atezolizumab and hyaluronidase-tqjs)	J9024
Tevimbra (tislelizumab-jsgr)	J9329
Unloxcyt (cosibelimab-ipdl)	J9275
Yervoy (ipilimumab)	J9228
Zynyz (retifanlimab-dlwr)	J9345

TABLE 3. DRUGS WITH MAXIMUM DURATION OF THERAPY BASED ON DIAGNOSIS:

Drug Name	Diagnosis	Maximum Duration of Therapy (Months/Years, Cycles, Doses)
Imfinzi (durvalumab)	Adjuvant treatment of resectable NSCLC	Max of 12 cycles
	Unresectable Stage III NSCLC	Max of 12 months
	Limited-stage SCLC	Max of 24 months
	BCG-Naïve, High-Risk NMIBC	Max of 13 cycles
Loqtorzi (toripalimab-tpzi)	Metastatic or recurrent, locally advanced nasopharyngeal carcinoma (in combination with cisplatin and gemcitabine)	Max of 2 years
Yervoy (ipilimumab)	Unresectable or metastatic melanoma	Max of 4 Doses
	Adjuvant treatment of melanoma	Max of 4 Doses if given every 3 weeks **OR** Max of 3 years if given every 12 weeks
	Unresectable or metastatic melanoma (in combination with nivolumab [Opdivo])	Max of 4 Doses
	Advanced renal cell carcinoma (in combination with nivolumab [Opdivo])	Max of 4 Doses
	Microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) metastatic colorectal cancer (in combination with nivolumab [Opdivo])	Max of 4 Doses

	Hepatocellular carcinoma (in combination with nivolumab [Opdivo])	Max of 4 Doses
	Metastatic non-small cell lung cancer expressing PD-L1 (in combination with nivolumab [Opdivo])	Max of 2 years
	Metastatic or recurrent non-small cell lung cancer (in combination with nivolumab [Opdivo])	Max of 2 years
	Malignant pleural mesothelioma (in combination with nivolumab [Opdivo])	Max of 2 years
	Esophageal squamous cell carcinoma (in combination with nivolumab [Opdivo])	Max of 2 years

UNIVERSAL CRITERIA:

The drugs listed in this policy will be reviewed in accordance with criteria described below.

Please note select drugs are subject to additional and/or more comprehensive coverage criteria which can be found in the Drug Specific Criteria table:

1. Must prescribed by, or in consultation with an Oncologist, Hematologist, or appropriate specialist **AND**
2. Must have a diagnosis that meets **one** of the following:
    a. Approved by the U.S. Food and Drug Administration (FDA) **OR**
    b. A National Comprehensive Cancer Network (NCCN) category level 1 or 2A recommendation **OR**
    c. Satisfied by the criteria required for the applicable line of business (LOB) for the treatment of cancer in the Off-Label Use of FDA Approved Drugs policy (Pharmacy-32) **AND**
3. Step therapy requirements must be met for select drugs (see TABLE 5)

TABLE 4. DRUG SPECIFIC CRITERIA:

Drug specific criteria may include but is not limited to unique approval timeframes, step therapy requirements, and additional limitations to universal coverage criteria

TABLE 5. DRUGS WITH STEP THERAPY REQUIREMENTS:

- Applies to New Starts ONLY
- Step Therapy criteria listed below applies to all *shared* FDA labeled or compendia supported *indications/regimens*, defined as NCCN level of evidence 1 or 2A.
- Adequate medical justification includes but is not limited to a contraindication to the preferred product or intolerable side-effects that occurred while on therapy. Use of a non-preferred drug will still be considered appropriate for its FDA approved indication or NCCN compendia supported use if there is lack of disease progression following a trial of a preferred product.

Drug Name	Diagnosis	Requirement
	Metastatic Merkel Cell Carcinoma	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used
	Locally advanced or metastatic Urothelial Carcinoma	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used

Bavencio (avelumab)	Advanced Renal Cell Carcinoma (RCC) when used in combination with axitinib for first-line treatment	There must be adequate medical justification as to why Keytruda (pembrolizumab) containing treatment regimen cannot be used
	Gestational Trophoblastic Neoplasia	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used
Jemperli (dostarlimab-gxly)	Recurrent or metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) recurrent or advanced endometrial cancer	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used
	Primary advanced or recurrent endometrial cancer (except for carcinosarcoma)	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used
	Mismatch repair deficient (dMMR) recurrent or advanced solid tumors that have progressed following prior treatment and have no satisfactory alternative treatment options	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used
Libtayo (cemiplimab-rwlc)	Advanced non-small cell lung cancer (NSCLC) for PD-L1 50% or greater	There must be adequate medical justification as to why Keytruda (pembrolizumab) and Tecentriq (atezolizumab) cannot be used
	Metastatic or locally advanced Cutaneous squamous cell carcinoma (CSCC)	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used
Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph)	For all FDA approved and compendia supported indications	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used
Opdivo	Unresectable or metastatic melanoma (cutaneous) when requested as single-agent therapy	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used
	Adjuvant treatment of completely resected stage IIB, stage IIC, or stage III melanoma (does not apply to stage III if Clinical Satellite/In-Transit (CSIT) limited resectable)	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used
	Resectable (tumors ≥ 4 cm or node positive) non-small cell lung cancer (NSCLC) in the neoadjuvant setting when used in combination with either cisplatin/pemetrexed (nonsquamous) or cisplatin/gemcitabine (squamous) chemotherapy, as well as single agent therapy as adjuvant treatment after surgery	There must be adequate medical justification as to why Keytruda (pembrolizumab) containing regimen cannot be used

(nivolumab)/Opdivo Qvantig (nivolumab and hyaluronidase-nvhy)	Metastatic non-small cell lung cancer (NSCLC) with progression on or after platinum-based chemotherapy when requested as single-agent therapy with PD-L1 tumor proportion score (TPS) 1% or greater	There must be adequate medical justification as to why Keytruda (pembrolizumab) and Tecentriq (atezolizumab) cannot be used
	Adult classical Hodgkin lymphoma (cHL) that has relapsed after three or more lines of therapy	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used
	Recurrent or metastatic squamous cell carcinoma of the head and neck (HNSCC) with disease progression on or after a platinum-based therapy	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used
	Locally advanced or metastatic urothelial carcinoma with disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used
	As a single agent for metastatic colorectal cancer that is defective for mismatch repair/high microsatellite instability (dMMR/MSI-H) that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used
	Unresectable advanced or metastatic esophageal squamous cell carcinoma as first-line treatment in combination with fluoropyrimidine- and platinum-containing chemotherapy whose tumors express PD-L1 $\geq$1	There must be adequate medical justification as to why Keytruda (pembrolizumab) containing regimen cannot be used
	Advanced or metastatic gastric cancer, gastroesophageal junction cancer, and esophageal adenocarcinoma whose tumors express PD-L1 $\geq$ 1 in combination with fluoropyrimidine- and platinum-containing chemotherapy	There must be adequate medical justification as to why Keytruda (pembrolizumab) containing regimen cannot be used

Tevimbra (tislelizumab-jsgr)	First line treatment of unresectable or metastatic esophageal squamous cell carcinoma (ESCC) in combination with platinum-containing chemo whose tumors express PD-L1 (≥ 1)	There must be adequate medical justification as to why Keytruda (pembrolizumab) containing regimen cannot be used
	First line treatment of unresectable or metastatic HER2-negative gastric or gastroesophageal junction adenocarcinoma in combination with platinum and fluoropyrimidine-based chemotherapy	There must be adequate medical justification as to why Keytruda (pembrolizumab) containing regimen cannot be used
Unloxcyt (cosibelimab-ipdl)	Metastatic cutaneous squamous cell carcinoma (mCSCC) or locally advanced cutaneous squamous cell carcinoma (laCSCC)	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used
Yervoy (ipilimumab)	Unresectable or metastatic melanoma (cutaneous) when requested as a single-agent for second-line, or subsequent line therapy	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used
Zynyz (retifanlimab-dlwr)	As a single agent for locally recurrent or metastatic squamous cell carcinoma of the anal canal (SCAC) with disease progression on or intolerance to platinum-based chemotherapy	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used
	Recurrent locally advanced or metastatic Merkel Cell Carcinoma	There must be adequate medical justification as to why Keytruda (pembrolizumab) cannot be used

IMPORTANT INFORMATION ON ACCELERATED APPROVAL:

Please refer to the following FDA websites for up-to-date information on ongoing, verified, and withdrawn accelerated approval indications:

Ongoing Cancer Accelerated Approvals: https://www.fda.gov/drugs/resources-information-approved-drugs/ongoing-cancer-accelerated-approvals

Verified Clinical Benefit Cancer Accelerated Approvals: https://www.fda.gov/drugs/resources-information-approved-drugs/verified-clinical-benefit-cancer-accelerated-approvals

Withdrawn Cancer Accelerated Approvals*: https://www.fda.gov/drugs/resources-information-approved-drugs/withdrawn-cancer-accelerated-approvals

*Note: Individuals currently receiving treatment for a withdrawn indication should consult with their healthcare provider whether to remain on treatment. Coverage of a treatment with a withdrawn indication will only be considered should the patient be established on therapy prior to the withdrawal date listed on the FDA website

CODES:

Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. Codes may not be covered under all circumstances. Please read the policy and guidelines statements carefully. Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).
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HCPCS: See drug specific criteria for the associated HCPCS code

UPDATES:

Date	Revision
11/12/2026	Reviewed / P&T Committee Approval
10/01/2026	Revised
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11/03/2025	Revised
10/10/2025	Revised
09/11/2025	Revised
08/14/2025	Reviewed / P&T Committee Approval
07/01/2025	Revised
05/19/2025	Revised
05/08/2025	Reviewed / P&T Committee Approval
04/02/2025	Revised
03/06/2025	Revised
02/06/2025	P&T Committee Review & Approval
02/03/2025	Revised
01/17/2025	Revised
12/15/2024	Revised
11/21/2024	Reviewed / Approved P&T Committee
11/14/2024	Revised
09/27/2024	Revised
09/20/2024	Revised
06/20/2024	Revised
03/21/2024	Revised
01/04/2024	Revised
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05/2021	Revised
04/2021	Revised
03/2021	Revised
02/11/2021	P&T Committee Approval
12/2020	Created (moved from the Oncology Medical CRPA)

REFERENCES:

In addition to the full prescribing information for each individual drug and NCCN Drugs and Biologic Compendium, any references that have been utilized in creating drug specific criteria will be listed below.