Mirvetuximab Soravtansine-gynx (Elahere™)

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

The proposal is to add text/statements in red and to delete text/statements with strikethrough:
POLICY

INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Elahere is indicated for the treatment of adult patients with folate receptor-alpha positive, platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer, who have received one to three prior systemic treatment regimens.

Compendial Uses

Recurrent folate receptor-alpha positive, platinum-sensitive epithelial ovarian, fallopian tube, or primary peritoneal cancer

All other indications are considered experimental/investigational and not medically necessary.

DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:
Documentation of testing or laboratory results confirming folate receptor-alpha status, where applicable.

COVERAGE CRITERIA

Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer

Authorization of 12 months may be granted for treatment of folate receptor-alpha positive epithelial ovarian, fallopian tube, or primary peritoneal cancer ~~as a single agent or in combination with bevacizumab~~ when either ~~all~~ of the following criteria are met:

- ~~Member has folate receptor-alpha positive disease~~
- Member has platinum-resistant disease and all of the following criteria are met:
  - Member has received at least one prior systemic therapy
  - Requested medication will be used as a single agent or in combination with bevacizumab
- Member has recurrent platinum-sensitive disease and all of the following are met:
  - Member has received two prior lines of platinum based therapy
  - Requested medication will be used as a single agent

- Tumor is at least 75% positive for folate receptor-alpha expression
- ~~Member has received at least one prior systemic therapy~~

CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

REFERENCES

1. Elahere [package insert]. North Chicago, IL ~~Waltham, MA~~: AbbVie ~~ImmunoGen~~, Inc.; July 2025.
2. The NCCN Drugs & Biologics Compendium® © 2025 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed September 3, 2025.

EFFECTIVE DATE

ID_CHS_2025