

## Medical Policy Manual **Approved Rev: Do Not Implement until 7/31/25**

### **Cemiplimab-rwlc (Libtayo®)**

#### **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.

#### **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

###### Cutaneous Squamous Cell Carcinoma (CSCC)

Libtayo is indicated for the treatment of patients with metastatic CSCC or locally advanced CSCC who are not candidates for curative surgery or curative radiation.

###### Basal Cell Carcinoma (BCC)

Libtayo is indicated for the treatment of patients with locally advanced **or metastatic** BCC **who have been** previously treated with a hedgehog pathway inhibitor or for whom a hedgehog pathway inhibitor is not appropriate.

###### Non-Small Cell Lung Cancer (NSCLC)

- Libtayo, as a single agent, is indicated for the first-line treatment of adult patients with non-small cell lung cancer (NSCLC) whose tumors have high PD-L1 expression [Tumor Proportion Score (TPS)  $\geq$  50%] as determined by an FDA-approved test, with no EGFR, ALK or ROS1 aberrations, and is:
  - locally advanced where patients are not candidates for surgical resection or definitive chemoradiation or
  - metastatic
- Libtayo, in combination with platinum-based chemotherapy, is indicated for the first-line treatment of adult patients with NSCLC with no EGFR, ALK, or ROS1 aberrations and is:
  - locally advanced where patients are not candidates for surgical resection or definitive chemoradiation or
  - metastatic

##### Compendial Uses

- Squamous Cell Skin Cancer
- Basal Cell Skin Cancer
- Non-Small Cell Lung Cancer
- Vulvar Cancer
- Cervical Cancer
- **Vaginal Cancer**
- **Anal Carcinoma**
- **Small Bowel Adenocarcinoma**



## Medical Policy Manual **Approved Rev: Do Not Implement until 7/31/25**

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

### EXCLUSIONS

Coverage will not be provided for members who have experienced disease progression while on programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor therapy.

### DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:

- Documentation of programmed death ligand 1 (PD-L1) tumor expression, where applicable.
- Documentation of molecular testing for EGFR, ALK, ROS1, BRAF, NTRK, MET, or RET genomic tumor aberrations, where applicable.

### COVERAGE CRITERIA

#### Cutaneous Squamous Cell Carcinoma (CSCC)

Authorization of 6 months may be granted as single-agent neoadjuvant treatment of very high risk, locally advanced, unresectable, or regional cutaneous squamous cell carcinoma.

Authorization of 6 months may be granted for treatment of cutaneous squamous cell carcinoma when all of the following criteria are met:

- The disease is one of the following:
  - Metastatic
  - Locally advanced
  - Recurrent
- The member is not a candidate for curative surgery or curative radiation
- The requested medication will be used as a single agent

#### Basal Cell Carcinoma (BCC)

Authorization of 6 months may be granted for single-agent treatment of basal cell carcinoma in members who have received a hedgehog pathway inhibitor (e.g., vismodegib [Erivedge], sonidegib [Odomzo]) or for whom a hedgehog pathway inhibitor is not appropriate and when any of the following criteria are met:

- Member has locally advanced disease
- Member has nodal disease and surgery is not feasible
- Member has metastatic disease

#### Non-Small Cell Lung Cancer (NSCLC)

Authorization of 6 months may be granted for treatment of recurrent, advanced, or metastatic non-small cell lung cancer (NSCLC) when any of the following criteria are met:

- The requested medication will be used as first-line therapy and the tumor does not have EGFR exon 19 deletions or L858R mutations, ALK rearrangements, or ROS1 aberrations (unless testing is not feasible due to insufficient tissue) as either:
  - A single agent for tumors with a high PD-L1 expression [Tumor Proportion Score (TPS)  $\geq 50\%$ ], or
  - In combination with platinum-based chemotherapy



## Medical Policy Manual **Approved Rev: Do Not Implement until 7/31/25**

- The requested medication will be used as maintenance therapy following first-line cemiplimab-rwlc therapy and the tumor does not have EGFR exon 19 deletions or L858R mutations, ALK rearrangements, or ROS1 aberrations (unless testing is not feasible due to insufficient tissue) as either:
  - A single agent, or
  - In combination with pemetrexed
- The requested medication will be used as subsequent therapy in combination with platinum-based chemotherapy.

### **Vulvar Cancer**

Authorization of 6 months may be granted as subsequent therapy for advanced or recurrent/metastatic vulvar cancer when the requested medication will be used as a single agent.

### **Cervical Cancer**

Authorization of 6 months may be granted as subsequent therapy for recurrent or metastatic cervical cancer when the requested medication will be used as a single agent.

### **Vaginal Cancer**

Authorization of 6 months may be granted as subsequent therapy for recurrent or metastatic vaginal cancer when the requested medication will be used as a single agent.

### **Anal Carcinoma**

Authorization of 6 months may be granted as subsequent therapy for metastatic anal carcinoma when the requested medication will be used as a single agent.

### **Small Bowel Adenocarcinoma**

Authorization of 6 months may be granted as a single agent for treatment of either of the following:

- Advanced or metastatic small bowel adenocarcinoma with microsatellite instability-high (MSI-H), or mismatch repair deficient (dMMR), or polymerase epsilon/delta (POLE/POLD1) tumors
- Locally unresectable or medically inoperable small bowel adenocarcinoma with microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) tumors

## **CONTINUATION OF THERAPY**

### **Basal Cell Carcinoma or Cutaneous Squamous Cell Carcinoma**

Authorization of 6 months may be granted (up to 24 months total) for continued treatment in members requesting reauthorization for treatment of basal cell carcinoma or cutaneous squamous cell carcinoma who have not experienced disease progression or an unacceptable toxicity.

### **All Other Indications**

Authorization of 6 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.

## Medical Policy Manual **Approved Rev: Do Not Implement until 7/31/25**

### **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. Libtayo [package insert]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.; April 2024.
2. The NCCN Drugs & Biologics Compendium® © 2024 National Comprehensive Cancer Network, Inc. Available at: <https://www.nccn.org>. Accessed December 5, 2024.

**EFFECTIVE DATE**      7/31/2025

ID\_CHS