Telisotuzumab vedotin-tllv (Emrelis™)

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 Indication(s)
Emrelis is indicated for the treatment of adult patients with locally advanced or metastatic, non-squamous non-small cell lung cancer (NSCLC) with high c-Met protein overexpression [greater than or equal to 50% of tumor cells with strong (3+) staining], as determined by an FDA-approved test, who have received a prior systemic therapy.

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: c-Met protein expression status.

COVERAGE CRITERIA

Non-Small Cell Lung Cancer (NSCLC)

Authorization of 12 months may be granted for treatment of locally advanced or metastatic non-squamous NSCLC with high c-Met protein overexpression [greater than or equal to 50% of tumor cells with strong (3+) staining], for members who have received a 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. Emrelis [package insert]. North Chicago, IL: AbbVie Inc.; May 2025.

EFFECTIVE DATE

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