 Approved Revision: Do Not Implement until 8/31/21

Talimogene Laherparepvec (Imlygic®)

NDC CODE(S) 55513-0078-XX IMLYGIC 1000000PFU/ML Suspension (AMGEN)
55513-0079-XX IMLYGIC 100000000PFU/ML Suspension (AMGEN)

DESCRIPTION

Talimogene laherparepvec is a live, attenuated herpes simplex virus-1 for intralesional injection. It has been genetically modified to replicate within tumors and produce the immune stimulatory protein GM-CSF. This causes lysis of tumors followed by release of tumor-derived antigens. Together with the virally-derived GM-CSF, this may promote an antitumor immune response, but the exact mechanism of action is not known.

POLICY

- Talimogene laherparepvec for the treatment of melanoma is considered ***medically necessary*** if the medical appropriateness criteria are met. **(See Medical Appropriateness below.)**
- Talimogene laherparepvec for the treatment of other conditions/diseases is considered ***investigational.***

MEDICAL APPROPRIATENESS

INITIAL APPROVAL CRITERIA

- Patient is 18 years of age or older; **AND**

Universal Criteria

- Patient is not pregnant *(Note: Women of childbearing potential should be advised to use an effective method of contraception to prevent pregnancy during treatment)*; **AND**
- Patient is not immunocompromised (i.e., patients with a history of primary or acquired immunodeficient states, leukemia, lymphoma, AIDS, or other clinical manifestations of infection with human immunodeficiency viruses, and those on immunosuppressive therapy); **AND**
- Treatment (i.e., talimogene laherparepvec) will only be administered via intralesional injection; **AND**

Melanoma

- Patient has one of the following:
  - Unresectable, distant metastatic disease; **OR**
  - Unresectable or incomplete resection of nodal recurrence: **OR**
  - Limited resectable or unresectable stage III disease with clinical satellite or in-transit metastases; **OR**
  - Limited resectable or unresectable disease with local satellite and/or in-transit recurrence

RENEWAL CRITERIA

- Patient continues to meet universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in the Initial Approval Criteria; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: herpetic infection, injection site complications (necrosis, ulceration, cellulitis and systemic bacterial infection), immune-mediated events, plasmacytoma at injection site, obstructive airway disorder, etc.; **AND**
- Patient continues to have injectable lesions to treat; **AND**

- Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread.

DOSAGE/ADMINISTRATION

INDICATION	DOSE
Melanoma	**Initial Treatment** • Imlygic 10^6 (1 million) PFU per mL • Inject largest lesion(s) first • Prioritize injection of remaining lesion(s) based on lesion size until maximum injection volume is reached or until all injectable lesion(s) have been treated
	Second Treatment • Imlygic 10^8 (100 million) PFU per mL • 3 weeks after initial treatment • Inject any new lesion(s) (lesions that have developed since initial treatment) first. • Prioritize injection of remaining lesion(s) based on lesion size until maximum injection volume is reached or until all injectable lesion(s) have been treated.
	All subsequent treatments (including re-initiation) • Imlygic 10^8 (100 million) PFU per mL • 2 weeks after previous treatment • Inject any new lesion(s) (lesions that have developed since previous treatment) first. • Prioritize injection of remaining lesion(s) based on lesion size until maximum injection volume is reached or until all injectable lesion(s) have been treated.
The total injection volume for each treatment visit should not exceed 4 mL for all injected lesions combined. It may not be possible to inject all lesions at each treatment visit or over the full course of treatment. Previously injected and/or uninjected lesion(s) may be injected at subsequent treatment visits.	

Lesion Size (Longest Dimension)	Intralesional Injection Volume
> 5 cm	up to 4 mL
> 2.5 cm to 5 cm	up to 2 mL
> 1.5 cm to 2.5 cm	up to 1 mL
> 0.5 cm to 1.5 cm	up to 0.5 mL
≤ 0.5 cm	up to 0.1 mL

- Store and transport at −90°C to −70°C (−130°F to −94°F), thaw immediately prior to administration.
- Protect from light, store in the carton until use.

LENGTH OF AUTHORIZATION

Coverage will be provided for 6 months and may be renewed

DOSING LIMITS

Max Units (per dose and over time) [HCPCS Unit]:

Initial treatment: 4 billable units
Second treatment: 400 billable units occurring 3 weeks after initial treatment
All subsequent treatments: 400 billable units occurring 2 weeks after previous treatment

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.

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, the express terms of the health plan will govern.

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).

SOURCES

1. Imlygic [package insert]. Thousand Oaks, CA; Amgen Inc; October 2019. Accessed April 2021.
2. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) for talimogene laherparepvec. National Comprehensive Cancer Network, 2021. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed April 2021.
3. Andtbacka RHI, Kaufman HL, Collichio F, et al. Talimogene laherparepvec improves durable response rate in patients with advanced melanoma. J Clin Oncol. 2015;33:2780-2788.
4. Andtbacka RHI, Kaufman HL, Collichio F, et al. Talimogene laherparepvec improves durable response rate in patients with advanced melanoma. J Clin Oncol. 2015;33 (suppl Clinical Study protocol): doi:10.1200/JCO.2014.58.3377.
5. Lexicomp Online. (2021, February). AHFS DI. *Talimogene laherparepvec.* Retrieved May 4, 2021 from Lexicomp Online with AHFS.
6. MICROMEDEX Healthcare Series. Drugdex Evaluations. (2020, April). *Talimogene laherparepvec*. Retrieved May 4, 2021 from MICROMEDEX Healthcare Series.

EFFECTIVE DATE 8/31/2021

ID_MRx