JOHNS HOPKINS MEDICINE / JOHNS HOPKINS HEALTHCARE	Johns Hopkins HealthCare LLC **Pharmacy Public** **Medical Management Drug Policies**	*Policy Number*	MMDP047
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		Review Date	04/20/2022
	Subject **Imfinzi**	*Revision Date*	04/20/2022
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This document applies to the following Participating Organizations:

US Family Health Plan

Keywords: Infimzi

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I. POLICY

A. Imfinzi (durvalumab) will require prior authorization for medical benefit coverage to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.

II. POLICY CRITERIA

A. Imfinzi may be approved for patients who meet the following:
   1. Non-small cell lung cancer (NSCLC)
      a. Documentation has been submitted showing the following:
         I. Patient has a diagnosis of unresectable stage II or III NSCLC
         II. Disease has not progressed following concurrent platinum-based chemotherapy and radiation therapy
   2. Extensive-stage small cell lung cancer (ES-SCLC)
      a. Documentation has been submitted showing the following:
         I. Imfinzi will be used in combination with etoposide and either carboplatin or cisplatin as first-line treatment for ES-SCLC, and then will be used as monotherapy for maintenance

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Initial approval will be limited to 6 months of therapy
B. Continuation of therapy may be approved in 6-month intervals with documentation showing the patient is continuing to tolerate the regimen and there has not been disease progression while on treatment
   1. Indication-specific limitation: Approval for NSCLC treatment may be extended up to 12 months total under the Plan benefit

IV. EXCLUSIONS

A. Imfinzi will not be covered for the following:
   1. Patients that have experienced disease progression while on PD-1 or PDL1 inhibitor therapy
   2. Any indications or uses that are not FDA-approved, or guideline-supported

V. RECOMMENDED DOSAGE

Please refer to the FDA-approved prescribing information for indication-specific dosing details.

VI. CODES

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Note: The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member's specific benefit plan determines coverage.

Medication	HCPCS/CPT Code
Injection durvalumab, 10 mg	J9173

VII. REFERENCES

1. Imfinzi [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; July 2021.
2. The NCCN Drugs & Biologics Compendium® © 2022 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 4, 2022.

VIII. APPROVALS

Signature on file at JHHC

DATE OF REVISION	SUMMARY OF CHANGE
04/20/2022	Policy Creation

Review Dates: 04/20/2022

Revision Dates: