CareSource

PHARMACY POLICY STATEMENT **Georgia Medicaid**	
DRUG NAME	Imfinzi (durvalumab)
BILLING CODE	J9999
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 2400 mg every 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Imfinzi (durvalumab) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

UROTHELIAL CARCINOMA (UrC)

For **initial** authorization:

1. Member must be 18 year of age or older; AND
2. Medication must be prescribed by oncologist/hematologist; AND
3. Medication is being used for the treatment of patients with locally advanced or metastatic UrC who have disease progression during or following platinum-containing chemotherapy or have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy; AND
4. Member does **not** have ANY of the following:
   a) History of immunodeficiency;
   b) History of severe autoimmune disease;
   c) Medical conditions that required systemic immunosuppression (not to exceed 10 mg/day of prednisone or equivalent);
   d) Untreated CNS metastasis;
   e) HIV, Hep B or Hep C;
   f) Active tuberculosis.
5. **Dosage allowed:** Intravenous infusion 10 mg/kg every 2 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved.

CareSource considers Imfinzi (durvalumab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
06/22/2017	New policy for Imfinzi created.

References:

1. Imfinzi [package inset]. Wilmington, DE; AstraZeneca Pharmaceuticals: May 2017.

Effective date: 09/01/2017
Revised date: 06/22/2017