# PHARMACY POLICY STATEMENT

## Ohio Medicaid

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>Imfinzi (durvalumab)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BILLING CODE</td>
<td>J9999</td>
</tr>
<tr>
<td>BENEFIT TYPE</td>
<td>Medical</td>
</tr>
<tr>
<td>SITE OF SERVICE ALLOWED</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td>COVERAGE REQUIREMENTS</td>
<td>Prior Authorization Required (Non-Preferred Product)</td>
</tr>
<tr>
<td>QUANTITY LIMIT</td>
<td>2400 mg every 28 days</td>
</tr>
<tr>
<td>LIST OF DIAGNOSES CONSIDERED NOT MEDICALLY NECESSARY</td>
<td>Click Here</td>
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</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACTION/DESCRIPTION</th>
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<tbody>
<tr>
<td>06/22/2017</td>
<td>New policy for Imfinzi created.</td>
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</table>
References:


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