CARECONTINUUM™

UTILIZATION MANAGEMENT MEDICAL POLICY

POLICY: Oncology (Injectable) – Imlygic Utilization Management Medical Policy
- Imlygic® (talimogene laherparepvec intralesional injection – Amgen/BioVex)

REVIEW DATE: 04/08/2026

OVERVIEW

Imlygic, a genetically modified oncolytic viral therapy, is indicated for the local treatment of unresectable cutaneous, subcutaneous, and nodal lesions in patients with **melanoma** recurrent after initial surgery.[1]

Limitation of use: Imlygic has not been shown to improve overall survival or have an effect on visceral metastases.

Dosing

Initial dose of Imlygic is administered at 10^6 plaque forming units (PFU)/mL.[1] Subsequent doses are 10^8 PFU/mL administered 3 weeks after the first dose, then every 2 weeks. Total volume of Imlygic is up to 4.0 mL per treatment session. 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 lesions may be injected at subsequent treatment visits. Continue treatment for at least 6 months unless other treatment is required or until there are no injectable lesions to treat. Imlygic may be reinitiated if new unresectable cutaneous, subcutaneous, or nodal lesions appear after a complete response. Refer to the Appendix for injection volume associated with lesion size.

Guidelines

Imlygic is addressed in guidelines from National Comprehensive Cancer Network (NCCN):

- **Melanoma: Cutaneous**: NCCN guidelines (version 1.2026 –February 17, 2026) list Imlygic as an intralesional treatment option in multiple situations, such as primary/initial therapy or subsequent therapy for advanced, metastatic, recurrent, or unresectable disease (category 2A/2B).[2]
- **Merkel Cell Carcinoma**: NCCN guidelines (version 2.2026 – October 24, 2025) recommend Imlygic as a single-agent if the patient has progressed on anti-programmed death ligand-1 (PD-L1) or anti-programmed death receptor-1 (PD-1) therapy or if these agents are contraindicated for regional disease or distant (M1) metastatic disseminated disease.[3]

POLICY STATEMENT

Prior Authorization is recommended for medical benefit coverage of Imlygic. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indication. Extended approvals are allowed if the patient continues to meet the criteria and dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Imlygic as well as the monitoring required for adverse events and long-term efficacy, approval requires Imlygic to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA
Coverage of Imlygic is recommended in those who meet the following criteria:

FDA-Approved Indication

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1. Melanoma. Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii, and iii):
Note: This includes reinitiation in patients with new lesions following a complete response.
- **i.** Patient is ≥ 18 years of age; AND
- **ii.** Imlygic will be directly injected into advanced, metastatic, recurrent, or unresectable cutaneous, subcutaneous, or nodal lesions; AND
- **iii.** The medication will be prescribed by or in consultation with an oncologist, dermatologist, or surgeon; OR

B) Patient is Currently Receiving Imlygic. Approve for 1 year if the patient meets ALL of the following (i, ii, and iii):
- **i.** Patient has remaining injectable lesions for treatment; AND
- **ii.** According to the prescriber, the patient has not experienced clinically relevant disease progression (e.g., disease progression associated with a decline in performance status and/or alternative therapy was needed); AND
- **iii.** The medication will be prescribed by or in consultation with an oncologist, dermatologist, or surgeon.

Dosing. Approve the following dosing regimens:

A) The dose is ONE of the following (i or ii):
- **i.** The initial dose is 10^6 (1 million) plaque-forming units (PFU)/mL; OR
- **ii.** Subsequent doses are 10^8 (100 million) PFU per mL with the second dose given 3 weeks after the initial dose and all additional doses (including reinitiation) are given no more frequently than once every 2 weeks; AND

B) Up to a maximum of 4 mL is administered per treatment visit.

Other Uses with Supportive Evidence

2. Merkel Cell Carcinoma. Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):

A) Patient is ≥ 18 years of age; AND

B) Patient has regional or distant metastatic disease; AND

C) Patient meets ONE of the following (i or ii):
- **i.** Patient has a contraindication to programmed death receptor-1 (PD-1) blocking antibody or programmed death ligand-1(PD-L1) blocking antibody therapy; OR
  Note: Examples of programmed death receptor-1 (PD-1) blocking antibody or programmed death ligand-1 (PD-L1) blocking antibody includes: Bavencio (avelumab intravenous infusion), Keytruda (pembrolizumab intravenous infusion), Opdivo (nivolumab intravenous infusion), and Zynyz (retifanlimab-dlwr intravenous infusion).
- **ii.** Patient has progressed on programmed death receptor-1 (PD-1) blocking antibody or programmed death ligand-1 (PD-L1) blocking antibody therapy; AND
  Note: Examples of programmed death receptor-1 (PD-1) blocking antibody or programmed death ligand-1 (PD-L1) blocking antibody therapy includes: Bavencio (avelumab intravenous

infusion), Keytruda (pembrolizumab intravenous infusion), Opdivo (nivolumab intravenous infusion), and Zynyz (retifanlimab-dlwr intravenous infusion).

D) Medication is prescribed by or in consultation with an oncologist, dermatologist, or surgeon.

Dosing. Approve BOTH of the following (A and B):

A) The dose is ONE of the following (i or ii):
- **i.** The initial dose is 10^6 (1 million) plaque-forming units (PFU)/mL; OR
- **ii.** Subsequent doses are 10^8 (100 million) PFU per mL with the second dose given 3 weeks after the initial dose and all additional doses (including reinitiation) are given no more frequently than once every 2 weeks; AND

B) Up to a maximum of 4 mL is administered per treatment visit.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Imlygic is not recommended in the following situations:

1. **Concurrent Use with Anti-Herpetic Viral Agents.** Imlygic is a genetically modified, live, attenuated herpes simplex virus-1 that is sensitive to acyclovir. Anti-herpetic viral agents (e.g., acyclovir, valacyclovir, famciclovir) may interfere with efficacy.[1]

2. **Immunocompromised Patients.** Imlygic is contraindicated in patients who are immunocompromised, including those with a history of primary or acquired immunodeficient states, leukemia, lymphoma, acquired immunodeficiency syndrome, or other clinical manifestations of infection with human immunodeficiency viruses, and those on immunosuppressive therapy.[1]

3. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Imlygic® intralesional injection [prescribing information]. Thousand Oaks, CA: BioVex/Amgen; November 2024.
2. The NCCN Cutaneous Melanoma Clinical Practice Guidelines in Oncology (version 1.2026 – February 17, 2026). © 2026 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 2, 2026.
3. The NCCN Merkel Cell Carcinoma Clinical Practice Guidelines in Oncology (version 2.2026 – October 24, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 1, 2026.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes	04/10/2024
Annual Revision	**Melanoma:** The following verbiage, "This includes reinitiation in patients with new lesions following a complete response," was moved to a Note. The requirement of specialist was reworded to Imlygic will be administered by or in consultation with an oncologist, dermatologist, or surgeon. Previously it was, "Imlygic will be administered by or under the supervision of an oncologist, dermatologist, or surgeon." **Merkel Cell Carcinoma**: Indication and criteria were added to Other Uses with Supportive Evidence.	04/02/2025
Annual Revision	**Melanoma:** The specialist requirement was reworded to "The medication will be prescribed by or in consultation with an oncologist, dermatologist, or surgeon." Previously it was "Imlygic will be administered by or in consultation with an oncologist, dermatologist, or surgeon." **Merkel Cell Carcinoma**: The following requirements were changed from "Patient has contraindication or progressed on checkpoint immunotherapy" to "Patient has contraindication or progressed on programmed death receptor-1 (PD-1) blocking antibody or programmed death ligand-1(PD-L1) blocking antibody therapy." The wording of the Note was changed from "checkpoint immunotherapy includes…" to "examples of programmed death receptor-1 (PD-1) blocking antibody or programmed death ligand-1(PD-L1) blocking antibody therapy are…"	04/08/2026

APPENDIX

Lesion Size (longest dimension)	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