

Oncology Medication Clinical Coverage

Policy Number: MC/PC 030
Effective Date: June 1, 2025

[Instructions for Use](#)

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Related Policies

- Colony-Stimulating Factors (CSFs)
- Rituximab (Riabni™, Rituxan®, Ruxience®, & Truxima®)
- Sandostatin (octreotide acetate) LAR Depot® Injection (Non-Oncology Indications)
- Somatuline Depot (lanreotide) and Lanreotide Injection
- Xgeva (denosumab) injection, for subcutaneous use

Coverage Rationale

<Please refer to Medical Benefit Plan Sponsor for preferred medications. Preferred products may be updated and therefore subject to change>.

For coverage of Oncology Medications (listed in the table below) the following will be required:

- Either of the following:
 - Indications and uses of injectable oncology medications, including therapeutic radiopharmaceuticals, listed in the NCCN Drugs and Biologics Compendium with Categories of Evidence and Consensus of 1, 2A, and 2B are covered as medically necessary.
 - The medication is being used in individuals under the age of 19 years for oncology indications with NCCN or compendia support from national pediatric protocols.

OR

- For continuation of therapy for patients currently in the midst of an ongoing prescribed treatment regimen.

Oncology Products:

Below are oncology products covered by this medical policy:

Therapeutic Class	Products
bevacizumab products	Alymsys (bevacizumab-maly) Avastin (bevacizumab) Mvasi (bevacizumab-awwb) Vegzelma (bevacizumab-adcd) Zirabev (bevacizumab-bvzr)
interleukin-15 (IL-15) receptor agonist	Anktiva (nogapendekin alfa inbakicept-pmIn)

Therapeutic Class	Proc
programmed death-1 [PD-1]/programmed death-ligand 1 [PD-L1] inhibitors	Bavencio (avelumab) Imfinzi (durvalumab) Keytruda (pembrolizumab) Opdivo (nivolumab) Opdualag (nivolumab and relatlimab-rmbw) Tecentriq (atezolizumab)
rituximab products	Riabni (rituximab-arrx) Rituxan (rituximab) Rituxan Hycela (rituximab/hyaluronidase human, recombinant) Ruxience (rituximab-pvvr) Truxima (rituximab-abbs)
trastuzumab products	Herceptin (trastuzumab) Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) Herzuma (trastuzumab-pkrb) Kanjinti (trastuzumab-anns) Ogivri (trastuzumab-dkst) Ontruzant (trastuzumab-dttb) Trazimera (trastuzumab-qyyp)
trastuzumab/pertuzumab combination therapy	Herceptin (trastuzumab) + Perjeta (pertuzumab) Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) + Perjeta (pertuzumab) Herzuma (trastuzumab-pkrb) + Perjeta (pertuzumab) Kanjinti (trastuzumab-anns) + Perjeta (pertuzumab) Ogivri (trastuzumab-dkst) + Perjeta (pertuzumab) Ontruzant (trastuzumab-dttb) + Perjeta (pertuzumab) Phesgo (pertuzumab, trastuzumab, hyaluronidase-zzxf) Trazimera (trastuzumab-qyyp) + Perjeta (pertuzumab)
somatostatin analogs	Somatuline Depot (Lanreotide) lanreotide Sandostatin LAR (octreotide)

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPSC Code	Description
C9467	Injection, rituximab and hyaluronidase, 10 mg
J1930	lanreotide injection
J1932	lanreotide, (cipl), 1mg
J1950	leuprolide acetate (for depot suspension), 3.75 mg

HCPSC Code	Description
J9035	Injection, bevacizumab, 10 mg
J2353	Injection, octreotide, depot form for intramuscular injection, 1mg
J9022	Injection, atezolizumab, 10 mg
J9023	Injection, avelumab, 10 mg
J9028	Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram
J9173	Injection, durvalumab, 10 mg
J9217	Injection, leuprolide acetate (for depot suspension), 7.5 mg
J9271	Injection, pembrolizumab, 1 mg
J9299	Injection, nivolumab, 1 mg
J9298	Injection, nivolumab and relatlimab-rmbw, 3 mg/1 mg
J9310	Injection, rituximab, 100 mg
J9311	Injection, rituximab, hyaluronidase, 10 mg
J9312	Injection, rituximab, 10 mg
J9316	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, 10 mg
J9355	Injection, trastuzumab, 10 mg
J9356	Injection, trastuzumab, 10 mg and hyaluronidase-oysk
Q5107	Injection, bevacizumab-awwb, biosimilar (Mvasi), 10 mg
Q5112	Injection, trastuzumab-dttb, biosimilar (Ontruzant), 10 mg
Q5113	Injection, trastuzumab-pkrb, biosimilar (Herzuma), 10 mg
Q5114	Injection, trastuzumab-dkst, biosimilar (Ogivri), 10 mg
Q5115	Injection, rituximab-abbs, biosimilar (Truxima), 10 mg
Q5116	Injection, trastuzumab-qyyp, biosimilar (Trazimera), 10 mg
Q5117	Injection, trastuzumab-anns, biosimilar (Kanjinti), 10 mg
Q5118	Injection, bevacizumab-bvzr, biosimilar (Zirabev), 10 mg
Q5119	Injection, rituximab-pvvr, biosimilar (Ruxience), 10 mg
Q5123	Injection, rituximab-arrx, biosimilar (Riabni), 10mg
Q5126	Injection, bevacizumab-maly, biosimilar, (Alymsys), 10 mg
Q5129	Injection, bevacizumab-adcd, biosimilar, (Vegzelma), 10 mg

Clinical Evidence

The National Comprehensive Cancer Network® (NCCN) Guidelines are the recognized standard for clinical direction and policy in cancer care. They are developed and updated by 61 individual panels, comprising over 1,700 clinicians and oncology researchers from the 33 NCCN Member Institutions. They panels include multidisciplinary, disease- and issue-specific subspecialists who are clinicians, researchers, and advocates. Each guideline will undergo annual review where it is circulated for comment among the multidisciplinary faculty at each NCCN Member Institution.

These guidelines are a comprehensive set of guidelines detailing the sequential management decisions and interventions that currently apply to 97 percent of cancers affecting patients in the United States. In addition, separate guidelines provide recommendations for some of the key cancer prevention and screening topics as well as supportive care considerations.

Definitions for NCCN Categories

The specific definitions of the NCCN categories for recommendations are included below:

- **Category 1:** Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
- **Category 2A:** Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
- **Category 2B:** Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate;
- **Category 3:** Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

For the 'uniform NCCN consensus' defined in Category 1 and Category 2A, a majority Panel vote of at least 85% is required. For the 'NCCN consensus' defined in Category 2B, a Panel vote of at least 50% (but less than 85%) is required. Lastly, for recommendations where there is strong Panel disagreement regardless of the quality of the evidence, NCCN requires a Panel vote of at least 25% to include and designate a recommendation as Category 3. The large majority of the recommendations put forth in the Guidelines are Category 2A. Where categories are not specified within the Guidelines, the default designation for the recommendation is Category 2A.

The specific definitions of the NCCN Categories of Preference are:

- Preferred intervention: Interventions that are based on superior efficacy, safety, and evidence; and, when appropriate, affordability
- Other recommended intervention: Other interventions that may be somewhat less efficacious, more toxic, or based on less mature data; or significantly less affordable for similar outcomes
- Useful in certain circumstances: Other interventions that may be used for select patient populations (defined with recommendation)

References

1. The NCCN Drugs & Biologics Compendium® (NCCN Compendium®). Available at www.nccn.org. Accessed on April 23, 2025.
2. The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). Available at https://www.nccn.org/guidelines/category_1. Accessed on April 23, 2025.

Policy History/Revision Information

Date	Summary of Changes
10/18/2023	Approved by OptumRx P&T Committee
3/20/2024	Annual Review. Updates to applicable codes and references.
3/19/2025	Annual Review. Updated references. Addition of programmed death-1 [PD-1]/programmed death-ligand 1 [PD-L1] inhibitors: Bavencio (avelumab), Imfinzi (durvalumab), Keytruda (pembrolizumab), Opdivo (nivolumab), Opdualag (nivolumab and relatlimab-rmbw), Tecentriq (atezolizumab). No changes made to clinical criteria.
5/15/2025	Addition of Anktiva (nogapendekin alfa inbakicept-pmIn). Updated references.

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. The insurance reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

OptumRx may also use tools developed by third parties to assist us in administering health benefits. OptumRx Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Archived Policy Versions (Internal Only)

Effective Date	Policy Number	Policy Title
mm/dd/yyyy – mm/dd/yyyy	#####	Title of Policy Hyperlinked to KL or Other Internal Location

Nondiscrimination & Language Access Policy



Discrimination is Against the Law. Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation, gender identity and sex stereotypes), consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2). Aspirus Health Plan, Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aspirus Health Plan, Inc.:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters.
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Nondiscrimination Grievance Coordinator at the address, phone number, fax number, or email address below.

If you believe that Aspirus Health Plan, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a *grievance* with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1890
Southampton, PA 18966-9998
Phone: 1-866-631-5404 (TTY: 711)
Fax: 763-847-4010
Email: customerservice@aspirushealthplan.com

You can file a *grievance* in person or by mail, fax, or email. If you need help filing a *grievance*, the Nondiscrimination Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. This notice is available at Aspirus Health Plan, Inc.'s website: https://aspirushealthplan.com/webdocs/70021-AHP-NonDiscrim_Lang-Assist-Notice.pdf.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-332-6501 (TTY: 711).

Arabic: تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن أعلى رقم الهاتف 1-800-332-6501 (رقم هاتف الصم والبك : 711)

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-332-6501 (ATS: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-332-6501 (TTY: 711).

Hindi: यान द : य द आप िहंदी बोलते ह तो आपके िलए मु त म भाषा सहायता सेवाएं उपल थ ह 1-800-332-6501 (TTY: 711) पर कॉल कर ।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-332-6501 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-6501 (TTY: 711) 번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-6501 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-332-6501 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-332-6501 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1-800-332-6501 (TTY: 711).

Traditional Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-6501 (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-332-6501 (TTY: 711).

Pennsylvania Dutch: Wann du Deutsch (Pennsylvania German / Dutch) schwetzscht, kannst du mitaue Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-332-6501 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສັຽຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-332-6501 (TTY: 711).