

Clinical Policy: Irinotecan Liposome (Onivyde)

Reference Number: CP.PHAR.304

Effective Date: 02.01.17

Last Review Date: 11.21

Line of Business: Medicaid, HIM

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Irinotecan liposome injection (Onivyde[™]) is a topoisomerase inhibitor.

FDA Approved Indication(s)

Onivyde is indicated, in combination with fluorouracil and leucovorin, for the treatment of patients with metastatic adenocarcinoma of the pancreas after disease progression following gemcitabine-based therapy.

Limitation(s) of use: Onivyde is not indicated as a single agent for the treatment of patients with metastatic adenocarcinoma of the pancreas.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Onivyde is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Pancreatic Adenocarcinoma (must meet all):

1. Diagnosis of pancreatic adenocarcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age \geq 18 years;
4. Prescribed for use in combination with fluorouracil and leucovorin;
5. Request meets one of the following (a or b):*
 - a. Dose does not exceed 70 mg/m² every 2 weeks;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid and HIM.PA.154 for health insurance marketplace.

II. Continued Therapy

A. Pancreatic Adenocarcinoma (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Onivyde for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):*
 - a. New dose does not exceed 70 mg/m² every 2 weeks;
 - b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid and HIM.PA.154 for health insurance marketplace.

III. Diagnoses/Indications for which coverage is NOT authorized

- ### A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid and HIM.PA.154 for health insurance marketplace, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

NCCN: National Comprehensive Cancer Network

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): severe hypersensitivity reaction to Onivyde or irinotecan HCl
- Boxed warning(s): severe neutropenia and severe diarrhea; do not administer in patients with bowel obstruction

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Pancreatic adenocarcinoma	<ul style="list-style-type: none"> 70 mg/m² IV every 2 weeks prior to leucovorin and fluorouracil If homozygous for UGT1A1*28 allele: 50 mg/m² IV every 2 weeks. Increase the dose to 70 mg/m² as tolerated in subsequent cycles 	70 mg/m ² every 2 weeks

VI. Product Availability

Single-dose vial: 43 mg/10 mL

VII. References

1. Onivyde Prescribing Information. Cambridge, MA: Merrimack Pharmaceuticals, Inc.; June 2017. Available at: <https://www.onivyde.com/>. Accessed June 24, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed June 24, 2021.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9205	Injection, irinotecan liposome, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2018 annual review: added HIM Medical Benefit line of business; removed requirement to check for contraindication bowel obstruction; added COC; summarized NCCN and FDA-approved uses for improved clarity; added specialist involvement in care; references reviewed and updated.	07.31.18	11.18
4Q 2019 annual review: no significant changes; references reviewed and updated.	08.13.19	11.19
4Q 2020 annual review: added oncologist prescriber requirement; references reviewed and updated.	07.13.20	11.20
4Q 2021 annual review: no significant changes; references reviewed and updated.	06.24.21	11.21

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program

approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence.

Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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