Draft New Policy: Do Not Implement

Datopotamab deruxtecan-dlnk (Datroway®)

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

The proposal is to add text/statements in red and to delete text/statements with strikethrough:

POLICY

INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Datroway is indicated for the treatment of adult patients with unresectable or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative (IHC 0, IHC 1+ or IHC 2+/ISH-) breast cancer who have received endocrine based therapy and chemotherapy for unresectable or metastatic disease.

All other indications are considered experimental/investigational and not medically necessary.

DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review, where applicable: Test results confirming status of the following receptors:

- Human epidermal growth factor receptor 2 (HER2)
- Estrogen
- Progesterone

COVERAGE CRITERIA

Breast Cancer

Authorization of 12 months may be granted for treatment of breast cancer when all of the following criteria are met:

- The disease is unresectable or metastatic
- The cancer cells are hormone receptor positive and HER2-negative.
- The member has received prior treatment including endocrine based therapy and chemotherapy for unresectable or metastatic disease

CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

REFERENCES

1. Datroway [package insert]. Basking Ridge, NJ: Daiichi Sankyo, Inc; January 2025.

EFFECTIVE DATE

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