Draft New Policy: Do Not Implement

Nogapendekin alfa inbakicept-pmln (Anktiva®)

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.

POLICY

I. 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 Indication
Anktiva is indicated with Bacillus Calmette-Guérin (BCG) for the treatment of adult patients with BCG-unresponsive nonmuscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors.

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

II. CRITERIA FOR INITIAL APPROVAL

Bladder Cancer
Authorization of 6 months may be granted for treatment of bladder cancer when all of the following criteria are met:

1. The member has non-muscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors
2. The disease is Bacillus Calmette-Guerin (BCG)-unresponsive
3. The requested medication will be used in combination with Bacillus Calmette-Guerin (BCG)
4. The member will receive maintenance doses at months 4, 7, 10, 13 and 19 after induction therapy.

III. CONTINUATION OF THERAPY

Authorization of 12 months [for a total of 24 maintenance doses (37 months of treatment)] may be granted for continued treatment in members requesting reauthorization for an indication listed in Section II when there is no evidence of unacceptable toxicity or disease recurrence or progression while on the current regimen.

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

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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. Anktiva [package insert]. Bothell, WA: AGC Biologics; April 2024.

EFFECTIVE DATE

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