Toripalimab-tpzi (Loqtorzi)

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.

A. FDA-Approved Indications
   1. Loqtorzi is indicated, in combination with cisplatin and gemcitabine, for first-line treatment of adults with metastatic or with recurrent locally advanced nasopharyngeal carcinoma (NPC).
   2. Loqtorzi is indicated, as a single agent, for the treatment of adults with recurrent unresectable or metastatic NPC with disease progression on or after a platinum-containing chemotherapy.

B. Compendial Use
   Nasopharyngeal Carcinoma (NPC)

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

II. EXCLUSIONS

Coverage will not be provided for members who have experienced disease progression while on PD-1 or PD-L1 inhibitor therapy.

III. CRITERIA FOR INITIAL APPROVAL

Nasopharyngeal carcinoma (NPC)

Authorization of 6 months may be granted when either of the following criteria are met:

A. The requested medication will be used in combination with cisplatin and gemcitabine for the treatment of unresectable, metastatic or recurrent locally advanced NPC.
B. The requested medication will be used as a single agent for treatment of recurrent, unresectable or metastatic NPC with disease progression on or after a platinum-containing chemotherapy.

IV. CONTINUATION OF THERAPY

Authorization of 6 months (for up to 24 months total when being used as first line therapy) may be granted for continued treatment in members requesting reauthorization for an indication listed in Section III 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. Loqtorzi [package insert]. Redwood City, CA: Coherus BioSciences, Inc; October 2023.
2. The NCCN Drugs & Biologics Compendium 2024 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed March 6, 2024.

EFFECTIVE DATE 12/3/2024

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