Clinical Policy: Epcoritamab-bysp (Epkinly)

Reference Number: LA.PHAR.634
Effective Date:
Last Review Date: 08.08.23
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Please note: This policy is for medical benefit*

Description

Epcoritamab-bysp (Epkinly™) is a bispecific CD20-directed CD3 T-cell engager.

FDA Approved Indication(s)

Epkinly is indicated for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from indolent lymphoma, and high-grade B-cell lymphoma after two or more lines of systemic therapy.

This indication is approved under accelerated approval based on response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

Policy/Criteria

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

It is the policy of Louisiana Healthcare Connections that Epkinly is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Diffuse Large B-Cell Lymphoma (must meet all)**:**

1. Diagnosis of DLBCL (including DLBCL not otherwise specified, DLBCL arising from indolent lymphoma, high-grade B-cell lymphoma, HIV-related DLBCL, primary effusion lymphoma, HHV8-positive DLBCL not otherwise specified, and monomorphic post-transplant lymphoproliferative disorders);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Request meets one of the following (a or b):
5. Member/enrollee has received ≥ 2 lines of systemic therapy (*see Appendix B*);
6. Member/enrollee had partial response, no response, progressive, relapsed, or refractory disease following prior systemic therapy;
7. If member/enrollee has histologic transformation of indolent lymphoma to DLBCL, both of the following (a and b):
   a. Member/enrollee does not intend to proceed to transplant;

b. Member/enrollee has received systemic therapy that included an anthracycline-based regimen (*see Appendix B*);

8. Prescribed as a single agent;
9. Request meets one of the following (a or b):*
   a. Both of the following (i and ii):
      i. Cycle 1 step-up doses: Dose does not exceed all the following (1, 2, and 3):
         1) 0.16 mg on day 1;
         2) 0.8 mg on day 8;
         3) Two 4 mg/0.8 mL vials;
      ii. 48 mg per dose (one 48 mg vial; see *Section V* below for details on dosing schedule by cycle);
   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:
Medicaid – 6 months

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255 for Medicaid;
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: LA.PMN.53 for Medicaid.

II. Continued Therapy

A. Diffuse Large B-Cell Lymphoma (must meet all)**:**

1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member/enrollee is currently receiving Epkinly for a covered indication and has received this medication for at least 30 days;
2. Member/enrollee 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 48 mg per dose (one 48 mg vial; see *Section V* below for details on dosing schedule by cycle);
   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:
Medicaid – 12 months

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255 for Medicaid;
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND

criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: LA.PMN.53 for Medicaid.

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 policy – LA.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
DLBCL: diffuse large B-cell lymphoma
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Examples of First-Line Treatment Regimens		
RCHOP (Rituxan® (rituximab), cyclophosphamide, doxorubicin, vincristine, prednisone)	Varies	Varies
RCEPP (Rituxan® (rituximab), cyclophosphamide, etoposide, prednisone, procarbazine)	Varies	Varies
RCDOP (Rituxan® (rituximab), cyclophosphamide, liposomal doxorubicin, vincristine, prednisone)	Varies	Varies
DA-EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicine) + Rituxan® (rituximab)	Varies	Varies
RCEOP (Rituxan® (rituximab), cyclophosphamide, etoposide, vincristine, prednisone)	Varies	Varies
RGCVP (Rituxan®, gemcitabine, cyclophosphamide, vincristine, prednisone)	Varies	Varies
Pola-R-CHP (Polivy™ (polatuzumab vedotin-piiq), rituximab, cyclophosphamide, doxorubicin, prednisone)	Varies	Varies
Examples of Second-Line Treatment Regimens		
Bendeka® (bendamustine) ± Rituxan® (rituximab)	Varies	Varies
CEPP (cyclophosphamide, etoposide, prednisone, procarbazine) ± Rituxan® (rituximab)	Varies	Varies
CEOP (cyclophosphamide, etoposide, vincristine, prednisone) ± Rituxan® (rituximab)	Varies	Varies
DA-EPOCH ± Rituxan® (rituximab)	Varies	Varies
GDP (gemcitabine, dexamethasone, cisplatin) ± Rituxan® (rituximab)	Varies	Varies
gemcitabine, dexamethasone, carboplatin ± Rituxan® (rituximab)	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
GemOx (gemcitabine, oxaliplatin) ± Rituxan® (rituximab)	Varies	Varies
gemcitabine, vinorelbine ± Rituxan® (rituximab)	Varies	Varies
lenalidomide ± Rituxan® (rituximab)	Varies	Varies
Rituxan® (rituximab)	Varies	Varies
DHAP (dexamethasone, cisplatin, cytarabine) ± Rituxan® (rituximab)	Varies	Varies
DHAX (dexamethasone, cytarabine, oxaliplatin) ± Rituxan® (rituximab)	Varies	Varies
ESHAP (etoposide, methylprednisolone, cytarabine, cisplatin) ± Rituxan® (rituximab)	Varies	Varies
ICE (ifosfamide, carboplatin, etoposide) ± Rituxan® (rituximab)	Varies	Varies
MINE (mesna, ifosfamide, mitoxantrone, etoposide) ± Rituxan® (rituximab)	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): cytokine release syndrome and immune effector cell-associated neurotoxicity syndrome

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose

DLBCL	Administer in 28-day cycles until disease progression or unacceptable toxicity:
	• Cycle 1:
	  o Day 1: step-up dose 1 – 0.16 mg SC
	  o Day 8: step-up dose 2 – 0.8 mg SC
	  o Day 15: first full dose – 48 mg SC
	  o Day 22: 48 mg SC
	• Cycle 2 and 3; days 1, 8, 15, 22: 48 mg SC
	• Cycles 4 to 9; days 1 and 15: 48 mg SC
	• Cycle 10 and beyond; day 1: 48 mg SC
		See regimen

VI. Product Availability

Single-dose vials for injection: 4 mg/0.8 mL, 48 mg/0.8 mL

VII. References

1. Epkinly Prescribing Information. Plainsboro, NJ: Genmab US, Inc.; May 2023. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/761324s000lbl.pdf. Accessed June 1, 2023.

2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed June 5, 2023.
3. National Comprehensive Cancer Network. B-Cell Lymphomas Version 4.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed June 5, 2023.
4. Thieblemont C, Phillips T, Ghesquieres H, et al. Epcoritamab, a novel, subcutaneous CD3xCD20 bispecific T-cell-engaging antibody, in relapsed or refractory large B-cell lymphoma: Dose expansion in a phase I/II trial. J Clin Oncol. 2023 Apr 20; 41(12): 2238-2247.

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
J9999	Not otherwise classified, antineoplastic drugs
C9399	Unclassified drugs or biologicals

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted corporate to local policy.	08.08.23	

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. Louisiana Healthcare Connections 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.

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 Louisiana Healthcare Connections administrative policies and procedures.

This clinical policy is effective as of the date determined by Louisiana Healthcare Connections. 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. Louisiana Healthcare Connections 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/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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