Clinical Policy: Lutetium Lu 177 vipivotide tetraxetan (Pluvicto)

Reference Number: CP.PHAR.582
Effective Date: 06.01.22
Last Review Date: 05.24
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

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

Description

Lutetium Lu 177 vipivotide tetraxetan (Pluvicto ™) is a radioligand therapeutic agent.

FDA Approved Indication(s)

Pluvicto is indicated for the treatment of adult patients with prostate-specific membrane antigen (PSMA)-positive metastatic castration-resistant prostate cancer (mCRPC) who have been treated with androgen receptor (AR) pathway inhibition and taxane-based chemotherapy.

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 Pluvicto is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Metastatic Castration-resistant Prostate Cancer (must meet all)**:**

1. Diagnosis of metastatic CRPC;
2. Documentation of disease progression despite bilateral orchiectomy or other androgen deprivation therapy (ADT) (see *Appendix D*);
3. Documentation of PSMA-positive disease confirmed on a Ga-68-PSMA-11, F-18 piflufolastat, or F-18 flotufolastat positive emission tomography (PET) or computed tomography (CT) scan;
4. Prescribed by or in consultation with an oncologist or urologist;
5. Age ≥ 18 years;
6. Member will use a gondatropin-releasing hormone (GnRH) analog concurrently or has had a bilateral orchiectomy;
7. Failure of both of the following, unless contraindicated or clinically significant adverse effects are experienced or all are contraindicated (a and b):
   a. A taxane-based regimen (e.g. docetaxel, cabazitaxel);*
      **Prior authorization may be required for docetaxel and cabazitaxel*
   b. Abiraterone (Zytiga®), unless member has previously failed Yonsa® (abiraterone) or Xtandi® (enzalutamide);*
      **Prior authorization may be required for Zytiga, Yonsa, and Xtandi*
8. Pluvicto is not prescribed concurrently with cytotoxic chemotherapy, immunotherapy, radioligand therapy, or investigational therapy;

9. Request meets one of the following (a or b):*
   a. Dose does not exceed 7.4 GBq (200 mCi) every 6 weeks for up to 6 doses;
   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 (up to a total of 6 doses)

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 one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
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: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Metastatic Castration-resistant Prostate Cancer (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Pluvicto for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. Member has not received ≥ 6 doses (infusions) of Pluvicto;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 7.4 GBq (200 mCi) every 6 weeks for up to 6 doses;
   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: 6 months (up to a total of 6 doses)

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 one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

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: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

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

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.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ADT: androgen deprivation therapy
AR: androgen receptor
BSoC: best standard of care
CRPC: castration- resistant prostate cancer
CT: computed tomography
FDA: Food and Drug Administration
GnRH: gondatropin-releasing hormone
LHRH: luteinizing hormone-releasing hormone
NCCN: National Comprehensive Cancer Network
PET: positive emission tomography
PSMA: prostate- specific membrane antigen

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
abiraterone (Zytiga®)	1,000 mg PO QD (given in combination with prednisone)	1,000 mg/day; 2,000 mg/day if taking a strong CYP3A4 inducer
docetaxel	Androgen-deprivation therapy with docetaxel 75 mg/m^2 for 6 cycles	Varies
Jevtana® (cabazitaxel)	20 mg/m^2 IV every 3 weeks	25 mg/m^2 once every 3 weeks

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

None reported

Appendix D: General Information

- Castration-resistant prostate cancer is prostate cancer that progresses clinically, radiographically, or biochemically despite castrate levels of serum testosterone (< 50 ng/dL).
- Per the NCCN, androgen deprivation therapy (ADT) should be continued in patients with metastatic CRPC while additional therapies, including secondary hormone therapies, chemotherapies, immunotherapies, radiopharmaceuticals, and/or targeted therapies are applied.
- Examples of ADT include:
  - Bilateral orchiectomy (surgical castration)
  - Luteinizing hormone-releasing hormone (LHRH) agonist given with or without an anti-androgen:
    - LHRH agonists: Zoladex® (goserelin), leuprolide (Lupron Depot®, Eligard®), and Trelstar® (triptorelin)
    - Anti-androgens: bicalutamide (Casodex®), flutamide (Eulexin®), nilutamide (Nilandron®), Xtandi® (enzalutamide), Erleada® (apalutamide), Nubeqa® (darolutamide)
  - LHRH antagonists: Firmagon® (degarelix), Orgovyx® (relugolix)

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Metastatic CRPC	7.4 GBq (200 mCi) IV every 6 weeks for up to 6 doses	See dosing regimen

VI. Product Availability

Injection, single-dose vial: 1,000 MBq/mL (27 mCi/mL)

VII. References

1. Pluvicto Prescribing Information. Millburn, NJ: Novartis AG.; October 2022. Available at https://www.novartis.com/us-en/sites/novartis_us/files/pluvicto.pdf. Accessed January 10, 2024.
2. National Comprehensive Cancer Network. Prostate Cancer Version 4.2023. Available at https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf. Accessed January 22, 2024.
3. ClinicalTrials.gov. Study of 177Lu-PSMA-617 in Metastatic Castrate-Resistant Prostate Cancer (VISION). Available at https://clinicaltrials.gov/ct2/show/NCT03511664. Accessed January 22, 2024.
4. IPD Analytics. NOC Code Guide: Pluvicto (lutetium Lu 177 vipivotide tetraxetan) injection, for intravenous use by Advanced Accelerator Applications USA, Inc. Published April 2022.
5. IPD Analytics. New Drug Review: Pluvicto (lutetium Lu 177 vipivotide tetraxetan). Published April 6, 2022.

6. Virgo KS, Rumble B, de Wit R, et al. Initial Management of Non-Castrate Advanced, Recurrent or Metastatic Prostate Cancer. American Society of Clinical Oncology (ASCO). Published ahead of print April 3, 2023, DOI: 10.1200/JCO.20.03256. Available at: https://www.asco.org/practice-patients/guidelines/genitourinary-cancer#/9521. Accessed January 22, 2024.
7. Basch E, Loblaw DA, Oliver TK, et al. Systemic Therapy in Men with Metastatic Castration-Resistant Prostate Cancer (CRPC). American Society of Clinical Oncology (ASCO). Published online before print September 8, 2014. Available at: https://ascopubs.org/doi/full/10.1200/JCO.2013.54.8404. Accessed January 22, 2024.
8. Garje R, Rumble B, Parikh RA. Systemic Therapy Update on 177Lutetium-PSMA-617 for Metastatic Castration-Resistant Prostate Cancer: ASCO Rapid Recommendation. Journal of Clinical Oncology 2022. 40(31): 3664-3666. Available at: https://www.asco.org/practice-patients/guidelines/genitourinary-cancer#/9496.
9. Garje R, Rumble B, Parikh RA. Systemic Therapy Update on 177Lutetium-PSMA-617 for Metastatic Castration-Resistant Prostate Cancer: ASCO Guideline Rapid Recommendation Update. Journal of Clinical Oncology. November 6, 2023. Available at: https://ascopubs.org/doi/10.1200/JCO.23.02128. Accessed January 22, 2024.
10. Sartor O, de Bono J, Chi KN, et al. Lutetium-177-PSMA-617 for Metastatic Castration-Resistant Prostate Cancer. N Engl J Med. 2021 Sep 16; 385(12): 1091-1103.

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
A9607	Lutetium Lu 177 vipivotide tetraxetan, therapeutic, 1 millicurie

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	04.11.22	05.22
Added HCPCS code [A9607]. Template changes applied to other diagnoses/indications.	09.09.22	
2Q 2023 annual review: added clarification to approval duration is for up to a total of 6 doses; revised continued therapy approval duration from 12 to 6 months; for continued therapy added requirement that member has not received ≥ 6 doses (infusions) of Pluvicto; added piflufolastat F-18 as an additional radioactive diagnostic agent for identification of PSMA-positive disease; updated *Appendix D* examples of androgen deprivation therapy per NCCN; removed inactive HCPCS code A9699; references reviewed and updated.	01.06.23	05.23

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2024 annual review: added F-18 flotufolastat as an additional option to confirm PSMA-positive disease; references reviewed and updated.	01.10.24	05.24

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.

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.