Clinical Policy: Polatuzumab Vedotin-piiq (Polivy)

Reference Number: CP.PHAR.433
Effective Date: 09.01.19
Last Review Date: 08.25
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

Polatuzumab vedotin-piiq (Polivy®) is a CD79b-directed antibody-drug conjugate with activity against dividing B cells.

FDA Approved Indication(s)

Polivy is indicated:

- In combination with a rituximab product, cyclophosphamide, doxorubicin, and prednisone (R-CHP) is indicated for the treatment of adult patients who have previously untreated diffuse large B-cell lymphoma (DLBCL), not otherwise specified (NOS) or high-grade B-cell lymphoma (HGBL) and who have an International Prognostic Index (IPI) score of 2 or greater
- In combination with bendamustine and a rituximab product for the treatment of adult patients with relapsed or refractory DLBCL, NOS, after at least two prior therapies

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

I. Initial Approval Criteria

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

1. Diagnosis of one of the following B-cell lymphomas (a, b, c, d, or e):
   a. DLBCL (*see Appendix D for DLBCL subtypes*);
   b. HGBL;
   c. Post-transplant lymphoproliferative disorder (PTLD) (B-cell type) (off-label);
   d. One of the following HIV-related B-cell lymphoma subtypes (i, ii, iii, or iv) (off-label):
      i. HIV-related DLBCL;
      ii. Primary effusion lymphoma;
      iii. HHV8-positive diffuse large B-cell lymphoma, NOS;
      iv. HIV-related plasmablastic lymphoma;
   e. Histologic transformation of indolent lymphoma to DLBCL (off-label);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. One of the following (a or b):

a. For DLBCL (including histologic transformation of indolent lymphoma), HGBL, or PTLD only: All of the following (i, ii, and iii):
   i. If DLBCL or HGBL: Member has not previously received treatment;
   ii. Polivy is prescribed in combination with R-CHP* (*see Appendix B for rituximab products*);
   iii. Member has an IPI or stage modified IPI score ≥ 2;
b. For any B-cell lymphoma: All of the following (i, ii, and iii):
   i. One of the following (1 or 2):
      1) Member is not a candidate for allogeneic or autologous stem cell transplant or chimeric antigen receptor (CAR) T-cell therapy (including members who do not have access to CAR T-cell therapy);
      2) Prescribed as a bridging therapy while waiting for CAR T-cell therapy product to become available;
   ii. Member has received ≥ 1 prior therapy *(see Appendix B)*;*
   iii. Polivy is prescribed in one of the following ways (1, 2, or 3):
      1) As a single agent;
      2) Non-transplant or CAR T-cell therapy candidates only: In combination with Lunsumio™;
      3) In combination with bendamustine and/or a rituximab product (*see Appendix B for rituximab products*);*

**Prior authorization may be required for chemotherapy, Lunsumio, bendamustine, and rituximab products*

5. Request meets one of the following (a or b):*
   a. Dose does not exceed 1.8 mg/kg on Day 1 of a 21-day cycle, for a maximum of 6 cycles;
   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 (*medical justification supports requests for cycles beyond 6)*

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

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Polivy for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. Member meets one of the following (a or b):
   a. Member has received < 6 cycles of Polivy;
   b. Member has received less than the number of cycles recommended by NCCN for the covered indication;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 1.8 mg/kg on Day 1 of a 21-day cycle, for a maximum of 6 cycles;
   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: 12 months (*medical justification supports requests for cycles beyond 6*)

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.

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.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
CAR: chimeric antigen receptor
DLBCL: diffuse large B-cell lymphoma
FDA: Food and Drug Administration
FL: follicular lymphoma
HGBL: high-grade B-cell lymphoma
NCCN: National Comprehensive Cancer Network
NOS: not otherwise specified
PTLD: post-transplant lymphoproliferative disorder

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
Rituximab Products		
Rituxan® (rituximab), Truxima® (rituximab-abbs), Rituxan Hycela® (rituximab-hyaluronidase)	Varies	Varies
DLBCL *Regimen examples (NCCN)*		
bendamustine ± rituximab	Varies	Varies
CEPP (cyclophosphamide, etoposide, prednisone, procarbazine) ± rituximab	Varies	Varies
lenalidomide ± rituximab	Varies	Varies
HGBL *Regimen examples (NCCN)*		
DA-EPOCH-R (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin + rituximab)	Varies	Varies
RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone)	Varies	Varies
PTLD *Regimen examples (NCCN)*		
CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) + obinutuzumab or rituximab	Varies	Varies
CVP (cyclophosphamide,vincristine, prednisone) + obinutuzumab or rituximab	Varies	Varies
HIV-Related B-Cell Lymphoma *Regimen examples (NCCN)*		
R-EPOCH (rituximab, etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin)	Varies	Varies
CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) + rituximab	Varies	Varies
Histologic Transformation of Indolent Lymphoma to DLBCL *Regimen examples (NCCN)*		
RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone)	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
None reported

Appendix D: DLBCL Subtypes per the National Comprehensive Cancer Network (NCCN)

- DLBCL, NOS (*FDA-approved use*)
- DLBCL coexistent with follicular lymphoma of any grade
- DLBCL coexistent with extranodal marginal zone lymphoma (EMZL) of stomach
- DLBCL coexistent with EMZL of nongastric sites
- Follicular lymphoma grade 3
- Intravascular LBCL
- DLBCL associated with chronic inflammation
- ALK-positive LBCL
- EBV-positive DLBCL, NOS
- T-cell/histiocyte-rich LBCL
- LBCL with IRF4/MUM1 rearrangement
- Double expressor DLBCL
- Fibrin-associated LBCL
- Mediastinal gray zone lymphoma
- Primary mediastinal LBCL
- Gray zone lymphoma
- HGBL with translocations of MYC and BCL2 and/or BCL6
- HGBL, NOS (*FDA-approved use*)
- Primary cutaneous DLBCL

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
DLBCL	**Previously untreated DLBCL or HGBL** 1.8 mg/kg IV every 21 days for 6 cycles in combination with a rituximab product, cyclophosphamide, doxorubicin, and prednisone *(Administer Polivy, rituximab product, cyclophosphamide, and doxorubicin in any order on Day 1 after prednisone. Prednisone is administered on Days 1-5 of each cycle.)* **Relapsed or refractory DLBCL** 1.8 mg/kg IV every 21 days for 6 cycles in combination with bendamustine and a rituximab product *(Administer Polivy, bendamustine, and rituximab product in any order on Day 1 of each cycle.)*	1.8 mg/kg/dose

VI. Product Availability

Single-dose vials for injection after reconstitution: 30 mg, 140 mg

VII. References

1. Polivy Prescribing Information. South San Francisco, CA: Genentech, Inc.; April 2023. Available at: https://www.gene.com/download/pdf/polivy_prescribing.pdf. Accessed April 17, 2025.

2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed April 21, 2025.
3. National Comprehensive Cancer Network. B-Cell Lymphomas Version 2.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed April 21, 2025.

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
J9309	Injection, polatuzumab vedotin-piiq (Polivy)

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2021 annual review: no significant changes; HCPCS code updated; updated reference for HIM off-label use to HIM.PA.154 (replaces HIM.PHAR.21); references reviewed and updated.	04.30.21	08.21
3Q 2022 annual review: for DLBCL per NCCN modified to only require one prior therapy and allow use as a single agent, updated Appendix D with DLBCL subtypes to align with NCCN; for Section I,B Other NCCN Recommended Uses criteria set, removed HGBL as this is considered a DLBCL subtype, per NCCN modified to only require at least one prior therapy for all requests and require member is not a transplant candidate for all requests other than FL; references reviewed and updated.	05.02.22	08.22
Template changes applied to other diagnoses/indications.	09.26.22	
3Q 2023 annual review: RT4: added criteria for new indication as first-line treatment for DLBCL and HGBL, and updated FDA approved indications section to reflect full approval of the third-line DLBCL indication; for off-label uses, removed mantle cell lymphoma, revised nodal marginal zone lymphoma to indolent lymphoma, and revised "AIDs-related" to "HIV-related" per NCCN; updated Appendix D per NCCN; references reviewed and updated.	04.14.23	08.23
3Q 2024 annual review: consolidated FDA and NCCN recommended uses into one criteria set under the umbrella diagnosis of B-cell lymphoma; for first-line use, added stage modified IPI score as an alternate pathway per NCCN; allowed first-line use in histologic transformation of indolent lymphoma to DLBCL per NCCN; removed follicular lymphoma as a coverable off-label use as it is no longer supported by NCCN; references reviewed and updated.	05.20.24	08.24

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2025 annual review: per NCCN – for PTLD, removed specification that disease must be monomorphic and added option for use in combination with R-CHP for disease with IPI score ≥ 2; for second-line use, added that member is either not a candidate for CAR T-cell therapy or Polivy is prescribed as bridging therapy until CAR T-cell therapy becomes available and added option for use in combination with Lunsumio for non-transplant/CAR T-cell therapy candidates; references reviewed and updated.	05.13.25	08.25

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.