Clinical Policy: Dostarlimab-gxly (Jemperli)

Reference Number: CP.PHAR.540
Effective Date: 09.01.21
Last Review Date: 08.21
Line of Business: Commercial, HIM, Medicaid

Revision Log

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

Description

Dostarlimab-gxly (Jemperli™) is a programmed death receptor-1 (PD-1)–blocking antibody.

FDA Approved Indication(s)

Jemperli is indicated for the treatment of adult patients with mismatch repair deficient (dMMR) recurrent or advanced:

- Endometrial cancer (EC), as determined by an FDA-approved test, that has progressed on or following prior treatment with a platinum-containing regimen
- Solid tumors, as determined by an FDA-approved test, that have progressed on or following prior treatment and who have no satisfactory alternative treatment options

This indication is approved under accelerated approval based on tumor 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 has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Jemperli is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Endometrial Carcinoma (must meet all)**:**

1. Diagnosis of EC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is recurrent or advanced, and dMMR (i.e., disease is indicative of MMR gene mutation or loss of expression);
5. Disease has progressed following prior treatment with a platinum-containing regimen (e.g., carboplatin/cisplatin);
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 500 mg every 3 weeks for dose 1 through 4, followed by 1,000 mg 3 weeks after dose 4, then 1,000 mg every 6 weeks;
   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

B. Solid Tumor (must meet all):
1. Diagnosis of solid tumor (e.g., breast cancer, colon cancer, gastric cancer, hepatobiliary cancer, ovarian/fallopian tube/primary peritoneal cancer, rectal cancer, small bowel adenocarcinoma, occult primary cancer);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is recurrent or advanced, and dMMR (i.e., disease is indicative of MMR gene mutation or loss of expression);
5. Disease has progressed on or following prior treatment and who have no satisfactory alternative options;
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 500 mg every 3 weeks for dose 1 through 4, followed by 1,000 mg 3 weeks after dose 4, then 1,000 mg every 6 weeks;
   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

C. Other diagnoses/indications
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Jemperli and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):*
   a. Dose does not exceed 500 mg every 3 weeks for dose 1 through 4, followed by 1,000 mg 3 weeks after dose 4, then 1,000 mg every 6 weeks;
   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

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is

NOT authorized): 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 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

dMMR: mismatch repair deficient
EC: endometrial carcinoma
ST: Solid Tumor
FDA: Food and Drug Administration
NCCN: National Comprehensive Cancer Network

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
EC systemic therapies: carboplatin, cisplatin, carboplatin/paclitaxel, cisplatin/docetaxel, cisplatin/doxorubicin, cisplatin/doxorubicin/paclitaxel, carboplatin/paclitaxel/bevacizumab, carboplatin/paclitaxel/trastuzumab, cisplatin/ifosfamide	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

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
EC, solid tumors	Dose 1 through 4: 500 mg every 3 weeks Subsequent dosing beginning 3 weeks after Dose 4 (Dose 5 onwards): 1,000 mg every 6 weeks	See dosing regimen

VI. Product Availability

Single-dose vial: 500 mg/10 ml

VII. References

1. Jemperli Prescribing Information. Philadelphia, PA: GlaxoSmithKline LLC; April 2021. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2020/761223s000lbl.pdf. Accessed October 11, 2011.
2. Dostarlimab-hxly In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed October 11, 2011.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	04.29.21	08.21
RT4: added newly approved indication for solid tumors.	09.26.21	

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.