Polatuzumab vedotin-piiq (Polivy®)	Place of Service Office Administration Outpatient Facility Infusion Administration Infusion Center Administration HCPCS: J9309 per 1 mg

Condition(s) listed in policy *(see criteria for details)*

- B-cell lymphomas

AHFS therapeutic class: antineoplastic agent
Mechanism of action: CD79b-directed antibody–drug conjugate

(1) Special Instructions and Pertinent Information

Covered under the Medical Benefit, please submit clinical information for prior authorization review via fax.

(2) Prior Authorization/Medical Review is required for the following condition(s)

All requests for polatuzumab vedotin-piiq (Polivy®) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

B-cell lymphomas

1. One of the following B-cell lymphomas:
    a. AIDS-related B-cell lymphomas: DLBCL, primary effusion lymphoma, HHV8-positive DLBCL not otherwise specified, or plasmablastic lymphoma, or
    b. Diffuse large B-cell lymphoma (including histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma)
    c. Follicular lymphoma (FL)
    d. High-grade B-cell lymphoma (HGBL)
    e. Monomorphic post-transplant lymphoproliferative disorders (PTLD)
2. Either of the following:
    a. Being used as first-line therapy and meets the following:
        i. Used for DLBCL or HGBL, and
        ii. Used in combination with a rituximab product, cyclophosphamide, doxorubicin, and prednisone (R-CHP)

    OR

    b. Being used for second line and subsequent therapy, and one of the following:
        i. Being used as a single agent, or
        ii. Being used in combination with bendamustine, or
        iii. Being used in combination with a rituximab product, or
        iv. Being used in combination with bendamustine and a rituximab product

Covered Dose
Up to 1.8 mg/kg IV every 21 days (6 doses)

Coverage period
6 cycles

ICD-10:
B20, C82.00-C82.09, C82.10-C82.19, C82.20-C82.29, C82.30-C82.39, C82.40-C82.49, C82.50-C82.59, C82.60-C82.69, C82.80-C82.89, C82.90-C82.99, C83.30-C83.39, C83.80-C83.89, C83.90-C83.99, C85.10-C85.19, C85.20-C85.29, C85.80-C85.89, D47.Z1

(3) The following condition(s) DO NOT require Prior Authorization/Preservice

All requests for polatuzumab vedotin-piiq (Polivy®) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

(4) This Medication is NOT medically necessary for the following condition(s):

Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

(5) Additional Information

How supplied:

- 30 mg (lyophilized powder in a single-dose vial)
- 140 mg (lyophilized powder in a single-dose vial)

(6) References

- AHFS®. Available by subscription at http://www.lexi.com
- DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
- National Comprehensive Cancer Network Drugs & Biologics Compendium. Polivy® (2023). Available by subscription at: www.nccn.org.
- National Comprehensive Cancer Network. B-Cell Lymphomas (Version 5.2023). Available at: www.nccn.org
- Polivy® (Polatuzumab vedotin-piiq) [Prescribing Information]. South San Francisco, CA: Genentech, Inc.; 4/2023.

(7) Policy Update

Date of last revision: 3Q2023
Date of next review: 1Q2024
Changes from previous policy version:

- Section (2): B-cell lymphoma - Added coverage for first-line treatment of diffuse-large B-cell lymphoma (DLBCL) and high-grade B-cell lymphoma (HGBL) in combination with R-CHP
  Rationale: In April 2023, FDA approved Polivy in combination with R-CHP for first-line treatment of DLBCL and HGBL; NCCN category 1 support
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BSC Drug Coverage Criteria to Determine Medical Necessity
Reviewed by P&T Committee