

Promise Health Plan

# dinutuximab (Unituxin®)

# Medical Benefit Drug Policy

<u>Place of Service</u> Infusion Center Administration Office Administration Outpatient Facility Infusion Administration

# **Drug Details**

USP Category: ANTINEOPLASTICS Mechanism of Action: GD2-binding monoclonal antibody <u>HCPCS:</u> C9399:Unclassified drugs or biologicals J3490:Unclassified drugs J3590:Unclassified biologics J9999:Not otherwise classified, antineoplastic drugs <u>How Supplied:</u> I7.5 mg (single-use vial)

# Condition(s) listed in policy (see coverage criteria for details)

• Neuroblastoma, high-risk

### Special Instructions and pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

#### The following condition(s) require Prior Authorization/Preservice:

#### Neuroblastoma, high-risk

- 1. Patient has received prior first-line therapy, AND
- 2. Used in combination with Leukine (sargramostim), Proleukin (aldesleukin), and isotretinoin

### **Covered Doses:**

17.5 mg/m^2/day IV infusion (over 10 to 20 hours) for 4 consecutive days for up to 5 cycles. Cycles 1, 3, and 5 are 24 days in duration Cycles 2 and 4 are 32 days in duration

#### Coverage Period:

Up to 5 cycles (20 doses total) over one year

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Effective: 04/03/2024



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#### References

- 1. AHFS<sup>®</sup>. Available by subscription at http://www.lexi.com
- 2. DrugDex<sup>®</sup>. Available by subscription at http://www.micromedexsolutions.com
- 3. Unituxin<sup>®</sup> (Dinutuximab) [Prescribing information]. Research Triangle Park, NC: United Therapeutics Corp.; 9/2020.

#### **Review History**

Date of Last Annual Review: 1Q2024 Date of last revision: 04/03/2024 Changes from previous policy version:

• No clinical change to policy following routine annual review.

Blue Shield of California Medication Policy to Determine Medical Necessity Reviewed by P&T Committee