MEDICATION POLICY

Generic Name: Durvalumab

Therapeutic Class or Brand Name: Imfinzi™

Applicable Drugs (if Therapeutic Class)**:** N/A

Date of Origin: 5/18/17 **Date Last Reviewed/Revised:** _____

GPI Code: 2135302900

Prior Authorization Criteria (may be considered medically necessary when criteria I through V are met):

I. Documented diagnosis of locally advanced or metastatic urothelial carcinoma.

II. Documentation that one of the following criteria A or B is met:

A. Patient has disease progression during or following platinum-containing chemotherapy.

B. Patient has disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.

III. Imfinzi™ will be used as a single agent.

IV. Minimum age requirement: 18 years old.

V. Prescribing physician is an oncologist.

Exclusion Criteria:

- Prior treatment with a programmed death receptor-1 (PD-1)-blocking antibody or a programmed death-ligand 1 (PD-L1) blocking antibody (i.e. Imfinzi™, Keytruda®, Opdivo®, or Tecentriq®).

Other Criteria:

- N/A

Quantity/Days Supply Restrictions:

- 10 mg/kg every 2 weeks.

Approval Length:

- **Authorization:** 6 months.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing that current medical necessity criteria are met and that the medication is effective.

Disclaimer: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgment in providing the most appropriate care for their patients.

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MEDICATION POLICY

Appendix:

N/A

References:

1. https://www.azpicentral.com/imfinzi/imfinzi.pdf#page=1.
2. Medi-Span.

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