POLICY: Oncology (Injectable) – Imlygic Utilization Management Medical Policy
- Imlygic® (talimogene laherparepvec intralesional injection – Amgen)

EFFECTIVE DATE: 1/1/2021
LAST REVISION DATE: 09/16/2024

COVERAGE CRITERIA FOR: All Aspirus Medicare Plans

OVERVIEW

Imlygic is an oncolytic viral therapy indicated for the local treatment of unresectable cutaneous, subcutaneous, and nodal lesions in patients with melanoma recurrent after initial surgery.[1] Limitation of use: Imlygic has not been shown to improve overall survival or have an effect on visceral metastases. Safety and efficacy have not been established in patients < 18 years of age.

Dosing

In the pivotal trial, the initial dose of Imlygic was administered at 10^6 plaque forming units (PFU)/mL (to seroconvert herpes simplex virus-seronegative patients).[1] Subsequent doses were 10^8 PFU/mL administered 3 weeks after the first dose, then every 2 weeks. Total volume of Imlygic was up to 4.0 mL per treatment session. It may not be possible to inject all lesions at each treatment visit or over the full course of treatment. Previously injected and/or uninjected lesions may be injected at subsequent treatment visits. Continue treatment for at least 6 months unless other treatment is required or until there are no injectable lesions to treat. Imlygic may be reinitiated if new unresectable cutaneous, subcutaneous, or nodal lesions appear after a complete response. Refer to the Appendix for injection volume associated with lesion size.

Guidelines

The National Comprehensive Cancer Network (NCCN) guidelines for melanoma (version 2.2024 – April 3, 2024) list Imlygic as an option in multiple treatment situations, including for Stage III melanoma; for recurrent disease (including nodal recurrence); for disseminated metastatic disease; for metastatic or unresectable disease following disease progression or maximal clinical benefit from BRAF targeted therapy (category 1 as initial or subsequent therapy for stage III disease; all others category 2A), and in combination with Yervoy (ipilimumab intravenous infusion) for metastatic or unresectable disease as second-line or subsequent therapy for disease progression (category 2B).[4]

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POLICY STATEMENT

Prior Authorization is recommended for medical benefit coverage of Imlygic. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indication. Extended approvals are allowed if the patient continues to meet the criteria and dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Imlygic as well as the monitoring required for adverse events and long-term efficacy, approval requires Imlygic to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Imlygic is recommended in those who meet the following criteria:

FDA-Approved Indication

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1. Melanoma. Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy (This includes reinitiation in patients with new lesions following a complete response). Approve for 6 months if the patient meets ALL of the following (i, ii, and iii):

- **i.** Patient is ≥ 18 years of age; AND
- **ii.** Imlygic will be directly injected into advanced, metastatic, recurrent, or unresectable cutaneous, subcutaneous, or nodal lesions; AND
- **iii.** Imlygic will be administered by or under the supervision of an oncologist, dermatologist, or surgeon.

B) Patient is Currently Receiving Imlygic. Approve for 1 year if the patient meets ALL of the following (i, ii, and iii):

- **i.** Patient has remaining injectable lesions for treatment; AND
- **ii.** According to the prescriber, the patient has not experienced clinically relevant disease progression (e.g., disease progression associated with a decline in performance status and/or alternative therapy was needed); AND
- **iii.** Imlygic will be administered by or under the supervision of an oncologist, dermatologist, or surgeon.

Dosing. Approve the following dosing regimens:

A) The dose is ONE of the following (i or ii):

- **i.** The initial dose is 10^6 (1 million) plaque-forming units (PFU)/mL; OR

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ii. Subsequent doses are 10^8 (100 million) PFU per mL with the second dose given 3 weeks after the initial dose and all additional doses (including reinitiation) are given no more frequently than once every 2 weeks; AND

B) Up to a maximum of 4 mL is administered per treatment visit.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Imlygic is not recommended in the following situations:

1. **Concurrent Use with Anti-Herpetic Viral Agents.** Imlygic is a genetically modified, live, attenuated herpes simplex virus-1 that is sensitive to acyclovir. Anti-herpetic viral agents (e.g., acyclovir, valacyclovir, famciclovir) may interfere with efficacy.[1]

2. **Immunocompromised Patients.** Imlygic is contraindicated in patients who are immunocompromised, including those with a history of primary or acquired immunodeficient states, leukemia, lymphoma, acquired immunodeficiency syndrome, or other clinical manifestations of infection with human immunodeficiency viruses, and those on immunosuppressive therapy.[1]

3. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Imlygic intralesional injection [prescribing information]. Thousand Oaks, CA: BioVex/Amgen; February 2023.
2. Dharmadhikari N, Mehnert JM, Kaufman HL. Oncolytic virus immunotherapy for melanoma. *Curr Treat Options Oncol*. 2015;16(3):326.
3. Moehler M, Goepfert K, Heinrich B, et al. Oncolytic virotherapy as emerging immunotherapeutic modality: potential of parvovirus h-1. *Front Oncol*. 2014;4:92.
4. The NCCN Cutaneous Melanoma Clinical Practice Guidelines in Oncology (version 2.2024 – April 3, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 5, 2024.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes	04/05/2023
Annual Revision	No criteria changes	04/10/2024

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Aspirus P&T Review	Policy reviewed and approved by Aspirus P&T committee. Annual review process	09/16/2024

APPENDIX

Lesion Size (longest dimension)	Injection volume
> 5 cm	Up to 4 mL
> 2.5 cm to 5 cm	Up to 2 mL
> 1.5 cm to 2.5 cm	Up to 1 mL
> 0.5 cm to 1.5 cm	Up to 0.5 mL
≤ 0.5 cm	Up to 0.1 mL

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