

UTILIZATION MANAGEMENT MEDICAL POLICY

POLICY: Oncology (Injectable – Programmed Death Ligand-1) – Unloxcyt Utilization Management Medical Policy

- Unloxcyt™ (cosibelimab-ipdl intravenous infusion – Checkpoint Therapeutics)

EFFECTIVE DATE: 5/1/2025

LAST REVISION DATE: 12/10/2025

COVERAGE CRITERIA FOR: All Aspirus Plans

OVERVIEW

Unloxcyt, a programmed death ligand-1 blocking antibody, is indicated for the treatment of metastatic cutaneous squamous cell carcinoma or locally advanced cutaneous squamous cell carcinoma in adults who are not candidates for curative surgery or curative radiation.¹

Dosing Information

The recommended dose of Unloxcyt is 1,200 mg administered by intravenous infusion no more frequently than once every 3 weeks until disease progression or unacceptable adverse events.¹

POLICY STATEMENT

Prior Authorization is recommended for medical benefit coverage of Unloxcyt. 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. Because of the specialized skills required for evaluation and diagnosis of patients treated with Unloxcyt as well as the monitoring required for adverse events and long-term efficacy, approval requires Unloxcyt to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

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

FDA-Approved Indication

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- 1. Cutaneous Squamous Cell Carcinoma.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
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- A) Patient is \geq 18 years of age; AND
- B) Patient has locally advanced or metastatic disease; AND
- C) According to the prescriber, the patient is not a candidate for curative surgery or curative radiation therapy; AND
- D) Medication is prescribed by or in consultation with an oncologist.

Dosing. Approve 1,200 mg administered by intravenous infusion no more frequently than once every 3 weeks.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Unloxcyt is not recommended in the following situations:

1. 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. Unloxcyt intravenous infusion [prescribing information]. Waltham, MA: Checkpoint Therapeutics; November 2025.
2. The NCCN Drugs & Biologics Compendium. © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on December 2, 2025. Search term: cosibelimab.
3. The NCCN Squamous Cell Skin Cancer Clinical Practice Guidelines in Oncology (version 1.2026 – September 2, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed December 2, 2025, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	01/08/2025
Update	01/21/2025: Added National Comprehensive Cancer Network Squamous Cell Skin Cancer (version 1.2025 – January 17, 2025) clinical practice guideline recommendations to the policy.	NA
Aspirus P&T Review	Policy reviewed and approved by Aspirus P&T committee. Annual review process	03/10/2025
Aspirus P&T Review	Policy reviewed and approved by Aspirus P&T committee. Annual review process	09/15/2025
Annual Revision	No criteria changes.	12/10/2025