CarePartners of Connecticut MEDICARE ADVANTAGE

Medical Necessity Guidelines
Medical Benefit Drugs

Epkinly™ (epcoritamab-bysp)

Effective: March 1, 2024

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

☒ CarePartners of Connecticut Medicare Advantage HMO plans, Fax 617-673-0956
☒ CarePartners of Connecticut Medicare Advantage PPO plans, Fax 617-673-0956

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Accelerated approval of Epkinly (epcoritamab-bysp) was based on results from the EPCORE NHL-1 Phase 1/2 trial in patients with relapsed or refractory B-cell lymphoma. Patients received Epkinly subcutaneously with Cycle 1 step-up dosing consisting of a 0.16 mg priming dose once on Day 1, followed by an 0.8 mg intermediate dose once on Day 8, and subsequent full 48 mg doses once on Day 15 and Day 22. Cycles were every 28 days. On Cycles 2 and 3, patients received 48 mg on Days 1, 8, 15, and 22. On Cycles 4–9, patients received 48 mg on Days 1 and 15. From Cycle 10 and beyond, patients received 48 mg once every 28 days. Patients continued to receive Epkinly until disease progression or unacceptable toxicity. The overall response rate was determined to be 61% (95% confidence interval [CI]: 53, 69), with 38% of patients achieving complete responses. Among responders, with a median follow-up of 9.8 months, the estimated median duration of response was 15.6 months (95% CI: 9.7, not reached).

Food and Drug Administration – Approved Indications

Epkinly (epcoritamab-bysp) is a bispecific CD20-directed CD3 T-cell engager indicated for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma, not otherwise specified, including diffuse large B-cell lymphoma arising from indolent lymphoma, and high-grade B-cell lymphoma after two or more lines of systemic therapy.

This indication is approved under accelerated approval based on response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

Clinical Guideline Coverage Criteria

The plan may authorization coverage of Epkinly for Members when all of the following criteria are met:

1. Documented diagnosis of **one (1)** of the following:
    a. Relapsed or refractory diffuse large B-cell lymphoma, not otherwise specified, including diffuse large B-cell lymphoma arising from indolent lymphoma
    b. High-grade B-cell lymphoma

AND

2. The prescribing physician is an oncologist or hematologist

AND

3. Documentation the patient has received at least two prior lines of systemic therapy

Limitations

- The Cycle 1 Day 15 dosage of Epkinly requires inpatient hospitalization for up to 24 hours after administration. Epkinly, even though given in an inpatient setting, still requires prior authorization from the plan.

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
J9321	Injection, epcoritamab-bysp, 0.16 mg

References

1. Epkinly (epcoritamab-bysp) [prescribing information]. Plainsboro, NJ: Genmab US, Inc.; 2023 May.
2. Hutchings M, et al. Dose escalation of subcutaneous epcoritamab in patients with relapsed or refractory B-cell non-Hodgkin lymphoma: an open-label, phase 1/2 study. Lancet. 2021;398(10306):1157–1169.

Approval And Revision History

September 12, 2023: Reviewed by the Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

- November 2023: Administrative Update in support of calendar year 2024 Medicare Advantage and PDP Final Rule.
- February 13, 2024: Administrative update to add the Limitation The Cycle 1 Day 15 dosage of Epkinly requires inpatient hospitalization for up to 24 hours after administration. Epkinly, even though given in an inpatient setting, still requires prior authorization from the plan. Administration update to add new J Code J9321 to Medical Necessity Guideline (effective March 1, 2024)

Background, Product and Disclaimer Information

Point32Health prior authorization criteria to be applied to Medicare Advantage plan members is based on guidance from Medicare laws, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). When no guidance is provided, Point32Health uses clinical practice guidance published by relevant medical societies, relevant medical literature, Food and Drug Administration (FDA)-approved package labeling, and drug compendia to develop prior authorization criteria to apply to Medicare Advantage plan members. Medications that require prior authorization generally meet one or more of the following criteria: Drug product has the potential to be used for cosmetic purposes; drug product is not considered as first-line treatment by medically accepted practice guidelines, evidence to support the safety and efficacy of a drug product is poor, or drug product has the potential to be used for indications outside of the indications approved by the FDA. Prior authorization and use of the coverage criteria within this Medical Necessity Guideline will ensure drug therapy is medically necessary, clinically appropriate, and aligns with evidence-based guidelines. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests revisions.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guidelines not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.