09-J4000-02

Original Effective Date: 09/15/21

Reviewed: 09/11/24

Revised: 10/15/24

Subject: Amivantamab-vmjw (Rybrevant™)

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

Dosage/ Administration	Position Statement	Billing/Coding	Reimbursement	Program Exceptions	Definitions
Related Guidelines	Other	References	Updates		

DESCRIPTION:

Amivantamab-vmjw (Rybrevant), a bispecific epidermal growth factor receptor (EGFR) and MET receptor-directed antibody, was approved by the U.S. Food and Drug Administration (FDA) in May 2021 for the treatment of locally advanced or metastatic non-small cell lung cancer (NSCLC) with EGFR exon 20 insertion mutations, in patients whose disease has progressed on or after platinum-based chemotherapy. This indication is approved under accelerated approval based on overall response rate (ORR) and duration of response (DOR). Continued approval of amivantamab for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

The safety and efficacy of amivantamab was evaluated in a phase 1, open-label study of patients with metastatic or unresectable NSCLC and EGFR exon 20 mutations whose disease had progressed on or after platinum based chemotherapy (CHRYSALIS, NCT02609776). Included patients (median age, 62 years) received amivantamab 1050 mg (baseline body weight less than 80 kg) or 1400 mg (baseline body weight 80 kg or greater) once weekly for 4 weeks, then every 2 weeks thereafter until disease progression or unacceptable toxicity.

Amivantamab produced an overall response rate (ORR) of 40% (complete response, 3.7%) in cohort patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with EGFR exon 20 insertion mutations who had progressed on or after platinum-based chemotherapy (n=81) from the CHRYSALIS trial. The median duration of response (DOR) was 11.1 months, with 63% of patients having a DOR of 6 months or longer. Patients had adenocarcinoma (95%), had received prior immunotherapy (46%), had previously treated brain metastases (22%), and received a median of 2 prior therapies (range, 1 to 7).

National Comprehensive Cancer Network (NCCN) Guidelines for Non-Small Cell Lung Cancer (Version 7.2021) contain recommendations for the use of amivantamab in NSCLC.

POSITION STATEMENT:

Initiation of amivantamab-vmjw (Rybrevant) **meets the definition of medical necessity** for any of the following indications when all associated criteria is met:

1. Non-Small Cell Lung Cancer (NSCLC)
    a. Member is diagnosed with recurrent, advanced, or metastatic non-small cell lung cancer (NSCLC)
    b. Amivantamab is used for one of the following:
        i. First line therapy for EGFR exon 20 insertion mutation positive disease in combination with carboplatin and pemetrexed – laboratory documentation of mutation must be submitted
        ii. Subsequent therapy as a single agent for EGFR exon 20 insertion mutation positive disease – laboratory documentation of mutation must be submitted
        iii. First line therapy in combination with lazertinib for EGFR exon 19 deletion or exon 21 L858R disease – laboratory documentation of mutation must be submitted
        iv. Subsequent therapy for EGFR exon 19 deletion or exon 21 L858R or EGFR S768I, L861Q, and/or G719X mutation positive disease in combination with carboplatin and pemetrexed – laboratory documentation of mutation must be submitted
    c. Dose does not exceed:
        i. Weight less than 80 kg:
            1. Used as a single agent: 1050 mg (3 vials)
            2. Used as combination therapy: 1750 mg (5 vials)
        ii. Weight greater than or equal to 80 kg:
            1. Used as a single agent: 1400 mg (4 vials)
            2. Used as combination therapy: 2100 mg (6 vials)
2. Member has another FDA-approved or NCCN-supported diagnosis, and **BOTH** of the following criteria are met:
    a. **EITHER** of the following:
        i. Member is diagnosed with a condition that is consistent with an indication listed in the product's FDA-approved prescribing information (or package insert) **AND** member meets any additional requirements listed in the "Indications and Usage" section of the FDA-approved prescribing information (or package insert)
        ii. Indication **AND** usage is recognized in NCCN Drugs and Biologics Compendium as a Category 1 or 2A recommendation
    b. Dosage does not exceed the maximum recommended in the FDA-approved prescribing information or the maximum recommended by the applicable NCCN guidelines for the diagnosis

Approval duration: 6 months

Continuation of amivantamab-vmjw (Rybrevant) **meets the definition of medical necessity** when **ALL** of the following criteria are met:

1. Authorization/reauthorization has been previously approved by Florida Blue or another health plan in the past two years for treatment of NSCLC, or other FDA-approved or NCCN supported diagnosis, **OR** the member has previously met all indication-specific criteria.
2. Member's disease has not progressed on treatment with amivantamab with the following exception:
    a. Use is in combination with lazertinib for EGFR exon 19 deletion or exon 21 L858R disease as continuation of therapy following disease progression on amivantamab-vmjw plus lazertinib for asymptomatic disease, symptomatic brain lesions, or symptomatic systemic limited progression
3. Dose does not exceed:
    a. Weight less than 80 kg:
        i. Used as a single agent: 1050 mg (3 vials)
        ii. Used as combination therapy: 1750 mg (5 vials)
    b. Weight greater than or equal to 80 kg:
        i. Used as a single agent: 1400 mg (4 vials)
        ii. Used as combination therapy: 2100 mg (6 vials)

Approval duration: 1 year

DOSAGE/ADMINISTRATION:

THIS INFORMATION IS PROVIDED FOR INFORMATIONAL PURPOSES ONLY AND SHOULD NOT BE USED AS A SOURCE FOR MAKING PRESCRIBING OR OTHER MEDICAL DETERMINATIONS. PROVIDERS SHOULD REFER TO THE MANUFACTURER'S FULL PRESCRIBING INFORMATION FOR DOSAGE GUIDELINES AND OTHER INFORMATION RELATED TO THIS MEDICATION BEFORE MAKING ANY CLINICAL DECISIONS REGARDING ITS USAGE.

FDA-approved

- Single agent therapy:
    - Less than 80 kg body weight: 1050 mg weekly on weeks 1 to 5, then every 2 weeks starting at week 7
    - Greater than or equal to 80 kg: 1400 mg weekly on weeks 1 to 5, then every 2 weeks starting at week 7
- Combination therapy:
    - Less than 80 kg body weight: 1400 mg weekly on weeks 1 to 4, then 1750 mg every 3 weeks starting at week 7
    - Greater than or equal to 80 kg: 1750 mg weekly on weeks 1 to 4, then 2100 mg every 3 weeks starting at week 7

Dose Adjustments

- See product label for dose reductions due to adverse reactions

Drug Availability

- 350 mg/7 mL (50 mg/mL) solution in a single-dose vial

PRECAUTIONS:

Boxed Warning

- None

Contraindications

- None

Precautions/Warnings

- Infusion-Related Reactions (IRR): Interrupt infusion at the first sign of IRRs
- Interstitial Lung Disease (ILD)/Pneumonitis: Monitor for new or worsening symptoms indicative of ILD
- Dermatologic Adverse Reactions: May cause rash including acneiform dermatitis and toxic epidermal necrolysis
- Ocular Toxicity: Promptly refer patients with worsening eye symptoms to an ophthalmologist
- Embryo-Fetal Toxicity: Can cause fetal harm

BILLING/CODING INFORMATION:

HCPCS Coding

J9061	Injection, amivantamab-vmjw, 2 mg

ICD-10 Diagnosis Codes That Support Medical Necessity

C33	Malignant neoplasm of trachea
C34.00 – C34.92	Malignant neoplasm of bronchus or lung
C78.00 – 78.02	Secondary malignant neoplasm of lung

REIMBURSEMENT INFORMATION:

Refer to section entitled **POSITION STATEMENT**.

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Part D: Florida Blue has delegated to Prime Therapeutics authority to make coverage determinations for the Medicare Part D services referenced in this guideline.

Medicare Advantage: No National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) were found at the time of the last guideline review date.

DEFINITIONS:

None

RELATED GUIDELINES:

None

OTHER:

None

REFERENCES:

1. Clinical Pharmacology [Internet]. Tampa (FL): Gold Standard, Inc.; 2024 [cited 9/1/24]. Available from: http://www.clinicalpharmacology.com/.
2. ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine; 2000 Feb 29 - [cited 9/1/24]. Available from: http://clinicaltrials.gov/.
3. DRUGDEX® System [Internet]. Greenwood Village (CO): Thomson Micromedex; Updated periodically [cited 9/1/24].
4. Janssen Biotech. Rybrevant (amivantamab) injection. 2024. [cited 9/1/24]. In: DailyMed [Internet]. Bethesda (MD): National Library of Medicine. Available from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1466c070-9f97-4fa4-a955-6a6b59981fb8
5. Orphan Drug Designations and Approval [Internet]. Silver Spring (MD): US Food and Drug Administration; 2024 [cited 9/1/24]. Available from: http://www.accessdata.fda.gov/scripts/opdlisting/oopd/index.cfm/.

COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Pharmacy Policy Committee on 09/11/24.

GUIDELINE UPDATE INFORMATION:

09/15/21	New Medical Coverage Guideline.
10/01/21	Revision: Added HCPCS code C9083.
01/01/22	Revision: Added HCPCS code J9061 and deleted codes C9083 and J9999.
10/15/23	Review and revision to guideline; updated references.
06/15/24	Revision to guideline; updated position statement and dosing (NCCN).
10/15/24	Review and revision to guideline; updated position statement and references.