Clinical Policy: Copanlisib (Aliqopa)

Reference Number: LA.PHAR.357
Effective Date: 11.04.23
Last Review Date: 04.09.24
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

****Please note: This policy is for medical benefit****

Description

Copanlisib (Aliqopa®) is a phosphatidylinositol-3-kinase inhibitor.

FDA Approved Indication(s)

Aliqopa is indicated for the treatment of adult patients with relapsed follicular lymphoma (FL) who have received at least two prior systemic therapies.*

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**Accelerated approval was granted for this indication based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.*

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Louisiana Healthcare Connections that Aliqopa is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Follicular and Other B-Cell Lymphomas (must meet all)**:**

1. Diagnosis of one of the following B-cell lymphoma subtypes (a or b):
   a. FL;
   b. Marginal zone lymphoma (off-label) (i, ii, or iii):
      i. Splenic marginal zone lymphoma;
      ii. Nodal marginal zone lymphoma;
      iii. Extranodal marginal zone lymphoma (a or b):
         a) Gastric MALT lymphoma;
         b) Nongastric MALT lymphoma;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Relapsed/refractory disease after ≥ 2 prior therapies (*see Appendix B for examples*);*
   **Prior authorization may be required*
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 60 mg (1 vial) per week for 3 out of 4 weeks;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).
   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: LA.PMN.53 for Medicaid.

II. Continued Therapy

A. Follicular and Other B-Cell Lymphomas (must meet all)**:**
1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Aliqopa for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following* (a or b):
   a. New dose does not exceed 60 mg (1 vial) per week for 3 out of 4 weeks;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: LA.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – LA.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
FL: follicular lymphoma
NCCN: National Comprehensive Cancer Network

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Follicular Lymphoma *Examples of first-line, second-line and subsequent therapies:* • bendamustine + Gazyva® (obinutuzumab) or rituximab • CHOP (cyclophosphamide, doxorubicin, vincristine, predenisone) + Gazyva or rituximab • CVP (cyclophosphamide, vincristine, prednisone) + Gazyva or rituximab • Single-agent examples: rituximab; Revlimid® (lenalidomide) ± rituximab	Varies	Varies
Marginal Zone Lymphomas *Examples of first-line, second-line and subsequent therapies:* • bendamustine + rituximab, bendamustine + Gazyva® • RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone) • RCVP (rituximab, cyclophosphamide, vincristine, prednisone) • Single-agent examples: rituximab; Leukeran® (chlorambucil) ± rituximab; cyclophosphamide ± rituximab; Imbruvica® (ibrutinib); Revlimid ± rituximab; Copiktra® (duvelisib); Zydelig® (idelalisib)	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
FL	60 mg IV on Days 1, 8, and 15 of a 28-day treatment cycle on an intermittent schedule (3 weeks on/1 week off)	60 mg/dose/week

VI. Product Availability

Single-dose vial: 60 mg

VII. References

1. Aliqopa Prescribing Information. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; March 2023. Available at: www.aliqopa.com. Accessed June 30, 2023.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed July 10, 2023.

3. National Comprehensive Cancer Network. B-Cell Lymphomas Version 5.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. July 10, 2023.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9057	Injection, copanlisib, 1 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted corporate to local policy.	06.20.23	10.05.23
Annual review: no significant changes; references reviewed and updated.	04.09.24	

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.