

Drug Policy:

Keytruda™ (pembrolizumab)

POLICY NUMBER UM ONC_1263	SUBJECT Keytruda™ (pembrolizumab)	DEPT/PROGRAM UM Dept	PAGE 1 OF 5
DATES COMMITTEE REVIEWED 11/12/14, 10/14/15, 07/26/16, 08/24/16, 03/08/17, 06/14/17, 06/13/18, 05/08/19, 09/11/19, 10/09/19, 12/11/19, 02/12/20, 03/11/20, 04/08/20, 05/13/20, 06/10/20, 08/12/20, 09/09/20, 12/09/20	APPROVAL DATE December 9, 2020	EFFECTIVE DATE December 28, 2020	COMMITTEE APPROVAL DATES (latest version listed last) 11/12/14, 10/14/15, 07/26/16, 08/24/16, 03/08/17, 06/14/17, 06/13/18, 05/08/19, 09/11/19, 10/09/19, 12/11/19, 02/12/20, 03/11/20, 04/08/20, 05/13/20, 06/10/20, 08/12/20, 09/09/20, 12/09/20
PRIMARY BUSINESS OWNER: UM		COMMITTEE/BOARD APPROVAL Utilization Management Committee	
URAC STANDARDS HUM 1	NCQA STANDARDS UM 2	ADDITIONAL AREAS OF IMPACT	
CMS REQUIREMENTS	STATE/FEDERAL REQUIREMENTS	APPLICABLE LINES OF BUSINESS Commercial, Exchange, Medicaid	

I. PURPOSE

To define and describe the accepted indications for Keytruda (pembrolizumab) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

New Century Health (NCH) is responsible for processing all medication requests from network ordering providers. Medications not authorized by NCH may be deemed as not approvable and therefore not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

II. INDICATIONS FOR USE/INCLUSION CRITERIA

A. PREFERRED MEDICATION GUIDANCE FOR INITIAL REQUEST:

1. When health plan Medicaid coverage provisions—including any applicable PDLs (Preferred Drug Lists)—conflict with the coverage provisions in this drug policy, health plan Medicaid coverage provisions take precedence per the [Preferred Drug Guidelines OR](#)

2. When health plan Exchange coverage provisions-including any applicable PDLs (Preferred Drug Lists)-conflict with the coverage provisions in this drug policy, health plan Exchange coverage provisions take precedence per the [Preferred Drug Guidelines OR](#)
3. For Health Plans that utilize NCH UM Oncology Clinical Policies as the initial clinical criteria, the [Preferred Drug Guidelines shall follow NCH L1 Pathways](#) when applicable, otherwise shall follow NCH drug policies [AND](#)
4. Continuation requests of previously approved, non-preferred medication are not subject to this provision [AND](#)
5. When available, generic alternatives are preferred over brand-name drugs.

B. Melanoma

1. Keytruda (pembrolizumab) will be used as single agent for [ONE](#) of the following:
 - a. Adjuvant therapy for high-risk Stage III melanoma following complete resection of the primary tumor (when identified) and a complete regional lymph node dissection. [NOTE: The maximum total duration of therapy is 1 year in the adjuvant setting. OR](#)
 - b. For unresectable or metastatic melanoma and the member had no prior disease progression on a PD-L1/PD-1 inhibitor.
 - c. [NOTE: Preferred weight based dosing: Keytruda \(pembrolizumab\) 200 mg \(if 50 kg or more\) or 2 mg/kg \(if less than 50 kg\) for every 3 weeks dosing.](#)

C. Recurrent/Metastatic Squamous and Non-Squamous Non-Small Cell Lung Cancer (NSCLC)

1. [NOTE #1: The preferred agent, per NCH Policy and NCH Pathway, for first line and maintenance treatment of recurrent/metastatic NSCLC is Keytruda \(pembrolizumab\) over other PD-1 or PD-L1 inhibitors \[i.e. Opdivo \(nivolumab\), Tecentriq \(atezolizumab\)\].](#)
2. [NOTE #2: Keytruda \(pembrolizumab\) use in non-squamous/adenocarcinoma Non-Small Cell Lung Cancer, as a single agent or in combination with platinum-based chemotherapy REQUIRES that the member's NSCLC be negative for EGFR mutations and ALK rearrangements.](#)
3. Keytruda (pembrolizumab) will be used for [ONE](#) of the following:
 - a. As first line therapy:
 - i. As a single agent if member's NSCLC is negative for EGFR, ALK (biomarkers not required for squamous histology) [AND](#) the tumor PD-L1 expression (either CPS- Combined Positive Score, or TPS- Tumor Proportion Score) is $\geq 50\%$ [OR](#)
 - ii. As a single agent if member's NSCLC is negative for EGFR, ALK (biomarkers not required for squamous histology) [AND](#) the PDL1 is $\geq 1\%$ and concurrent chemotherapy cannot be given or is contraindicated [OR](#)
 - iii. In combination with pemetrexed and platinum chemotherapy in members with non-squamous histology if EGFR, ALK genomic alterations are negative, regardless of the PD-L1 level [OR](#)
 - iv. In combination with carboplatin and paclitaxel or nab-paclitaxel (if there is a history of a severe allergic reaction, anaphylaxis, or intolerance to paclitaxel) in members with squamous cell histology.
 - b. As continuation maintenance therapy, in combination with pemetrexed (non-squamous) or as a single agent, in members who have achieved complete response/partial response/stable disease following first line therapy with a regimen that included chemotherapy + Keytruda (pembrolizumab).
 - c. As subsequent therapy as a single agent for tumors with PD-L1 expression levels $\geq 1\%$ and the member had no prior progression on a PD-L1/PD-1 inhibitor.

D. Head and Neck

1. The member has unresectable, recurrent, or metastatic NON-nasopharyngeal squamous cell carcinoma of the head and neck **AND** Keytruda (pembrolizumab) will be used for:
 - a. First line therapy
 - i. As a single agent for tumors that express PD-L1 (either CPS- Combined Positive Score or TPS-Tumor Proportion Score) $\geq 1\%$ **OR**
 - ii. In combination with fluorouracil and platinum chemotherapy, regardless of the PD-L1 expression score.
 - b. Subsequent therapy as a single agent for disease progression on or after platinum-based chemotherapy, regardless of the PD-L1 expression score.

E. Hodgkin's Lymphoma

1. The member has refractory or relapsed Hodgkin's Lymphoma and is not a candidate for HSCT and Keytruda (pembrolizumab) will be used as a single agent.

F. Urothelial Carcinoma including Upper Urinary Tract Carcinoma and Carcinoma of Urethra

1. **NOTE:** Per NCH Policy and NCH Pathway, Keytruda (pembrolizumab) is the preferred checkpoint inhibitor rather than Opdivo (nivolumab), Tecentriq (atezolizumab), Bavencio (avelumab) or Imfinzi (durvalumab), for subsequent therapy of metastatic/recurrent urothelial carcinoma.
2. The member has recurrent/metastatic urothelial cancer and Keytruda (pembrolizumab) will be used for members who are not eligible for platinum-containing chemotherapy or who have disease progression during or after platinum containing chemotherapy.

G. Colorectal Cancer

1. Therapy as a single agent for initial or subsequent therapy for members with unresectable/metastatic colorectal cancer whose tumors show deficient mismatch repair/microsatellite instability-high [dMMR/MSI-H]. **This requires confirmation of dMMR/MSI-High status.**

H. Gastric Cancer or Esophageal and Esophagogastric Junction Cancers

1. The member has unresectable locally advanced, recurrent, or metastatic gastric cancer or esophageal and EGJ adenocarcinoma **AND**
2. Keytruda (pembrolizumab) will be used as single agent as any of the following:
 - a. As second-line or subsequent therapy for microsatellite instability-high (MSI-H) or deficient mismatch repair (dMMR) tumors **OR**
 - b. As third-line or subsequent therapy as a single agent for gastric adenocarcinoma with PD-L1 expression levels by CPS of ≥ 1 .

I. Cervical Cancer

1. The member has recurrent or metastatic microsatellite instability-high (MSI-H) or deficient mismatch repair (dMMR) cervical cancer or PD-L1 positive, CPS or TPS $\geq 1\%$, tumors **AND**
2. Keytruda (pembrolizumab) will be used as a single agent as subsequent therapy following disease progression on or after prior chemotherapy treatment.

J. Hepatobiliary Cancers

1. Keytruda (pembrolizumab) will be used in members with hepatocellular carcinoma who have disease progression on or after Nexavar (sorafenib), Lenvima (Lenvatinib), or Stivarga (regorafenib) unless intolerance or contraindications exist to the above 3 agents **OR**

2. For subsequent treatment as a single agent for progression on or after systemic treatment for unresectable or metastatic disease that is microsatellite instability-high (MSI-H) and/or deficient mismatch repair (dMMR).

K. Merkel Cell Carcinoma (MCC)

1. Keytruda (pembrolizumab) will be used as a single agent in members with recurrent/locally advanced/metastatic Merkel Cell Carcinoma regardless of the line of therapy.

L. Renal Cell Carcinoma (RCC)

1. **NOTE:** The preferred regimen for first line therapy if metastatic renal cell carcinoma- IMDC Intermediate and High Risk - is Nivolumab with or without Ipilimumab. Please refer to *UM ONC_1274 Opdivo (nivolumab) policy*.
2. Keytruda (pembrolizumab) + Inlyta (axitinib) combination therapy is not a preferred option.
3. Keytruda (pembrolizumab) will be used as a single agent for subsequent therapy if member has not received prior PD-1 inhibitor therapy.

M. Primary Mediastinal Large B-Cell Lymphoma (PMBCL)

1. Keytruda (pembrolizumab) will be used as a single agent in relapsed or refractory primary mediastinal large B-cell lymphoma.

N. Endometrial Carcinoma

1. Keytruda (pembrolizumab) will be used as a single agent as subsequent-line systemic therapy for unresectable or metastatic, microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) tumor that has progressed following prior treatment **OR**
2. Keytruda (pembrolizumab) will be used with Lenvima (lenvatinib) as subsequent therapy after disease progression on prior chemotherapy, in members whose tumors are MSI-Stable (for members with tumors that are MSI-High, single agent Keytruda (pembrolizumab) is recommended per policy in this clinical setting- item N.1. above).

O. Small Cell Lung Cancer (SCLC)

1. Keytruda (pembrolizumab) will be used as a single agent as subsequent therapy **AND**
2. The member had no prior disease progression on a PD-L1/PD-1 inhibitor.

P. Cutaneous Squamous Cell Carcinoma (CSCC)

1. **NOTE:** The preferred agent, per NCH Policy, for the treatment of members with recurrent or metastatic cutaneous squamous cell carcinoma is Libtayo (cemiplimab-rwlc) over Keytruda (pembrolizumab). Please refer to *UM ONC_1089 for Libtayo (cemiplimab-rwlc) policy*.

Q. Microsatellite Instability-High or Mismatch Repair Deficient Cancer

1. Keytruda (pembrolizumab) may be used for any of the following solid tumors that have progressed following prior treatment and are positive for microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR):
 - a. Bone cancer
 - b. Breast cancer
 - c. Cervical cancer
 - d. Esophageal and Esophagogastric Junction Cancers
 - e. Gastric Cancer
 - f. Gallbladder Cancer
 - g. Intrahepatic/Extrahepatic Cholangiocarcinoma
 - h. Poorly Differentiated (High Grade)/Large or Small Cell neuroendocrine tumors

- i. Ovarian cancer
- j. Prostate cancer
- k. Endometrial carcinoma

III. EXCLUSION CRITERIA

- A. Disease progression on Keytruda (pembrolizumab) containing regimen or prior checkpoint inhibitor (PD-1/PD-L1) therapy.
- B. Lack of EGFR, ALK and ROS-1 test results when being used in the first line therapy (as a single agent or in combination with chemotherapy) of metastatic/recurrent non-squamous/adenocarcinoma Non-Small Cell Lung Cancer.
- C. Length of Keytruda (pembrolizumab) treatment is greater than 24 months (except for Melanoma up to 12 months).
- D. Indications not supported by CMS recognized compendia or acceptable peer reviewed literature.

IV. MEDICATION MANAGEMENT

- A. Please refer to the FDA label/package insert for details regarding these topics.

V. APPROVAL AUTHORITY

- A. Review – Utilization Management Department
- B. Final Approval – Utilization Management Committee

VI. ATTACHMENTS

- A. None

VII. REFERENCES

- A. Keytruda prescribing information. Merck & Co. Inc. 2020.
- B. Clinical Pharmacology Elsevier Gold Standard. 20120
- C. Micromedex® Healthcare Series: Thomson Micromedex, Greenwood Village, Co. 2020.
- D. National Comprehensive Cancer Network. Cancer Guidelines and Drugs and Biologics Compendium. 2020.
- E. AHFS Drug Information. American Society of Health-Systems Pharmacists or Wolters Kluwer Lexi-Drugs. Bethesda, MD. 2020.