Clinical Policy: Copanlisib (Aliqopa)

Reference Number: CP.PHAR.357
Effective Date: 12.01.17
Last Review Date: 11.24
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

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

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.

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.

***Bayer, the manufacturer of Aliqopa, announced the voluntary withdrawal of its application for adult patients with relapsed FL who have received at least two prior systemic therapies** (*see Appendix D*)**.**

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 health plans affiliated with Centene Corporation® 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. Authorization is not permitted. Member may not initiate therapy with Aliqopa. If member is currently using Aliqopa proceed to section II.A. Follicular and Other B-Cell Lymphomas for continued therapy (*see Appendix D*).

Approval duration: Not applicable

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 one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

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: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

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

1. Currently receiving medication via Centene 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:
Medicaid/HIM – 12 months
Commercial – 6 months or duration of request, whichever is less

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 one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
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: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.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 – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.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;	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

Appendix D: Aliqopa Market Withdrawal

- Aliqopa received accelerated approval from the FDA in September 2017 based on CHRONOS-1, an open-label, single-arm phase 2 study. The FDA required clinical benefit to be confirmed through the CHRONOS-4 study. In the study, the addition of Aliqopa to standard immunochemotherapy regimens did not meet the primary endpoint of progression-free survival benefit versus the standard immunochemotherapy control arm in patients with relapsed FL.
- Bayer announced the voluntary withdrawal of its new drug application for Aliqopa on November 13, 2023. Bayer stated it was exploring access options for patients currently receiving Aliqopa who have experienced a favorable response to treatment, whose treating physician supports continuing treatment with Aliqopa, and for whom there may be no suitable alternative treatments available. No new patients should be prescribed Aliqopa per Bayer's press release. Approval was withdrawn as of March 18, 2024.
- The NCCN also removed Aliqopa as a treatment option for both FL and marginal zone lymphoma (NCCN guideline B-cell lymphomas version 2.2024).

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.; September 2023. Available at: https://www.hcp.aliqopa-us.com/. Accessed July 17, 2024.
2. National Comprehensive Cancer Network. B-Cell Lymphomas Version 2.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. August 7, 2024.
3. Bayer press release. Bayer provides update on Aliqopa. Available at: https://www.bayer.com/en/us/news-stories/update-on-aliqopar. Accessed August 7, 2024.
4. Federal Register. Bayer HealthCare Pharmaceuticals Inc.; withdrawal of approval of new drug application for Aliqopa (copanlisib) for injection, 60 milligrams per vial, a notice by the FDA on 03/18/2024. Available at: https://www.federalregister.gov/documents/2024/03/18/2024-05619/bayer-healthcare-pharmaceuticals-inc-withdrawal-of-approval-of-new-drug-application-for-aliqopa. Accessed August 7, 2024.

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	P&T Approval Date
4Q 2020 annual review: added Commercial line of business; no significant changes; references reviewed and updated.	07.13.20	11.20
4Q 2021 annual review: no significant changes; revised HIM-Medical Benefit to HIM; references reviewed and updated.	08.06.21	11.21
4Q 2022 annual review: no significant changes; references reviewed and updated. Template changes applied to other diagnoses/indications.	08.02.22	11.22
4Q 2023 annual review: no significant changes; revised commercial line of business approval duration to "6 months or duration of request, whichever is less"; references reviewed and updated.	06.30.23	11.23
4Q 2024 annual review: removed initial approval criteria due to manufacturer withdrawal; added information regarding the market withdrawal to Appendix D; references reviewed and updated.	07.17.24	11.24

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. The Health Plan 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. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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 Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. 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. The Health Plan 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 the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.