Mass General Brigham
Health Plan

Polivy (polatuzumab vedotin-piiq)
Effective 06/01/2020

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit (NLX)		
Specialty Limitations	N/A		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview

Polatuzumab vedotin is an antibody drug conjugate (ADC) directed at CD79b which consists of 3 components: 1) a CD79b-specific humanized IgG1 antibody; 2) a microtubule-disrupting agent, monomethylauristatin E (MMAE); and 3) a protease cleavable linker (which covalently conjugates MMAE to the polatuzumab antibody). The conjugate binds to CD79b (B-cell specific cell surface protein commonly expressed in mature B cell lymphomas) and forms a complex which is internalized within the cell and releases MMAE. MMAE binds to the tubules and disrupts the cellular microtubule network, inducing cell cycle arrest (G2/M phase) and apoptosis.

Coverage Guidelines

Authorization may be granted for members who are currently receiving treatment with Polivy excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization may be granted for members when all the following criteria are met, and documentation is provided:

1. The member is ≥ 18 years of age
2. The member has a diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL)
3. Provider specialty is oncology and/or hematology or medication is being prescribed in consultation with an oncologist/hematologist
4. The member has had adverse reaction, inadequate response, or contraindication to two systemic therapies for DLBCL

Continuation of Therapy

Reauthorization requires physician documentation of improvement of member's condition.

Limitations
Authorizations will be approved for 12 months

References

1. Polivy [package insert]. South San Francisco, CA: Genentech, Inc.; June 2019.
2. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: B-Cell Lymphomas. Version 4.2019. https://www.nccn.org. Accessed June 19, 2019.
3. The NCCN Drugs & Biologics Compendium® © 2019 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed June 19, 2019.

Review History
01/23/2020 – Reviewed P&T Mtg (effective 6/1/20).