

**Rybrevent<sup>®</sup> (amivantamab-vmjw)**  
**Effective 04/01/2022**

<b>Plan</b>	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	<b>Program Type</b>	<input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
<b>Benefit</b>	<input type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> Medical Benefit (NLX)		
<b>Specialty Limitations</b>	N/A		
<b>Contact Information</b>	<b>Specialty Medications</b>		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	<b>Non-Specialty Medications</b>		
	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	
	<b>Medical Specialty Medications (NLX)</b>		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
<b>Exceptions</b>	N/A		

### Overview

Rybrevent is indicated for the treatment of locally advanced or metastatic non–small cell lung cancer (NSCLC) in adults with epidermal growth factor receptor (EGFR) exon 20 insertion mutations (as detected by an approved test) with disease progression on or after platinum-based chemotherapy.

### Coverage Guidelines

Authorization may be reviewed for members new to the plan who are currently receiving treatment with Rybrevent 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 has a diagnosis of advanced or metastatic non-small cell lung cancer (NSCLC)
2. The prescriber specialty is an oncologist or medication is written in consultation with an oncologist
3. Member has EGFR exon 20 insertion mutation
4. Member meets ONE Of the following:
  - Inadequate response or adverse reaction to at least one platinum-based chemotherapy regimen (e.g., carboplatin, oxaliplatin, cisplatin)
  - Contraindication to ALL platinum-based chemotherapy (e.g., carboplatin, oxaliplatin, cisplatin)
5. The medication will be used as a single agent.

**Continuation of Therapy**

Reauthorization will be granted when physician provides attestation of positive response to therapy and member has not shown signs of excessive toxicity.

**Limitations**

1. Initial approvals and reauthorizations will be granted for 12 months

**References**

1. Rybrevant (amivantamab) [prescribing information]. Horsham, PA: Janssen Biotech Inc; July 2021.

**Review History**

01/19/2022 – Reviewed and Created Jan P&T. Effective 04/01/2022.

