allways HEALTH PARTNERS

# Rybrevant® (amivantamab-vmjw)
## Effective 04/01/2022

<table>
<tr><td>Plan</td><td>☒ MassHealth<br>☐ MH UPPL<br>☐Commercial/Exchange</td><td rowspan="2">Program Type</td><td rowspan="2">☒ Prior Authorization<br>☐ Quantity Limit<br>☐ Step Therapy</td></tr>
<tr><td>Benefit</td><td>☐ Pharmacy Benefit<br>☒ Medical Benefit (NLX)</td></tr>
<tr><td>Specialty Limitations</td><td colspan="3">N/A</td></tr>
<tr><td rowspan="9">Contact Information</td><td colspan="3">Specialty Medications</td></tr>
<tr><td>All Plans</td><td>Phone: 866-814-5506</td><td>Fax: 866-249-6155</td></tr>
<tr><td colspan="3">Non-Specialty Medications</td></tr>
<tr><td>MassHealth</td><td>Phone: 877-433-7643</td><td>Fax: 866-255-7569</td></tr>
<tr><td>Commercial</td><td>Phone: 800-294-5979</td><td>Fax: 888-836-0730</td></tr>
<tr><td>Exchange</td><td>Phone: 855-582-2022</td><td>Fax: 855-245-2134</td></tr>
<tr><td colspan="3">Medical Specialty Medications (NLX)</td></tr>
<tr><td>All Plans</td><td>Phone: 844-345-2803</td><td>Fax: 844-851-0882</td></tr>
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<tr><td>Exceptions</td><td colspan="3">N/A</td></tr>
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## Overview
Rybrevant 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 AllWays Health Partners who are currently receiving treatment with Rybrevant 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. Appropriate dosing
4. Cancer has EGFR exon 20 insertion mutation
5. 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)

**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.

## Disclaimer

AllWays Health Partners complies with applicable federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex.