

**Clinical Policy: Copanlisib (Aliqopa)**

Reference Number: CP.PHAR.357

Effective Date: 10.17.17

Last Review Date: 11.19

Line of Business: Medicaid, HIM-Medical Benefit

[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.*

**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. Diagnosis of one of the following B-cell lymphoma subtypes (a or b):
  - a. Follicular lymphoma;
  - b. Marginal zone lymphoma (off-label) (i, ii, or iii):
    - i. Splenic marginal zone lymphoma;
    - ii. Nodal marginal zone lymphoma;
    - iii. Extranodal marginal zone lymphoma (a or b):
      - a) Gastric MALT lymphoma;
      - b) Nongastric MALT lymphoma;
2. Disease is relapsed or refractory;
3. Prescribed by or in consultation with an oncologist or hematologist;
4. Age  $\geq$  18 years;
5. Member has received  $\geq$  2 prior systemic therapies (*see examples at Appendix B*);  
*\*Prior authorization may be required for systemic therapies.*
6. Request meets one of the following (a or b):\*
  - a. Dose does not exceed 60 mg (1 vial) per week for 3 out of 4 weeks;
  - b. 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: 6 months**

**B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid and HIM-Medical Benefit.

**II. Continued Therapy**

**A. All Indications in Section I (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: 12 months**

**B. Other diagnoses/indications (must meet 1 or 2):**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.  
**Approval duration: Duration of request or 6 months (whichever is less);** or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid and HIM-Medical Benefit.

**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.PMN.53 for Medicaid and HIM-Medical Benefit 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
<b>Follicular Lymphoma</b> <i>Examples of first-line, second-line and subsequent therapies:</i> <ul style="list-style-type: none"> <li>• bendamustine + Gazyva<sup>®</sup> (obinutuzumab) or rituximab</li> <li>• CHOP (cyclophosphamide, doxorubicin, vincristine, predenison) + Gazyva or rituximab</li> <li>• CVP (cyclophosphamide, vincristine, prednisone) + Gazyva or rituximab</li> <li>• <u>Single-agent examples:</u> rituximab; Revlimid<sup>®</sup> (lenalidomide) ± rituximab</li> </ul>	Varies	Varies
<b>Marginal Zone Lymphomas</b> <i>Examples of first-line, second-line and subsequent therapies:</i> <ul style="list-style-type: none"> <li>• bendamustine + rituximab</li> <li>• RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone)</li> <li>• RCVP (rituximab, cyclophosphamide, vincristine, prednisone)</li> <li>• <u>Single-agent examples:</u> rituximab; Leukeran<sup>®</sup> (chlorambucil) ± rituximab; cyclophosphamide ± rituximab; Imbruvica<sup>®</sup> (ibrutinib); Revlimid ± rituximab; Copiktra<sup>®</sup> (duvelisib); Zydelig<sup>®</sup> (idelalisib)</li> </ul>	Varies	Varies

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

*Appendix C: Contraindications/Boxed Warnings*

None reported

**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.; May 2019. Available at: [www.aliqopa.com](http://www.aliqopa.com). Accessed August 13, 2019.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at [www.nccn.org](http://www.nccn.org). Accessed July 22, 2019.
3. National Comprehensive Cancer Network. B-Cell Lymphomas Version 4.2019. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/b-cell.pdf](https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf). Accessed July 22, 2019.

## CLINICAL POLICY

### Copanlisib

#### 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
Policy created	10.17.17	11.17
4Q 2018 annual review: no significant changes; HIM-Medical added specialist prescriber requirement; references reviewed and updated.	07.26.18	11.18
4Q 2019 annual review: NCCN recommended B-cell lymphoma subtypes added - Appendix B required therapy examples expanded accordingly; relapsed or refractory disease added; dosing detail - 3 out of 4 weeks - added per PI; FDA/NCCN dosing limitation added; references reviewed and updated.	08.27.19	11.19

#### 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.

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## CLINICAL POLICY

### Copanlisib

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.

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**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.

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