PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Injectable) – Elahere Prior Authorization Policy
- Elahere® (mirvetuximab soravtansine-gynx intravenous infusion – ImmunoGen)

REVIEW DATE: 06/05/2024

OVERVIEW
Elahere, a folate receptor alpha (FRα)-directed antibody and microtubule inhibitor conjugate, is indicated for the treatment of FRα positive, platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer, in adults who have received one to three prior systemic treatment regimens.[1]

Guidelines
The National Comprehensive Cancer Network (NCCN) ovarian cancer (including fallopian tube cancer and primary peritoneal cancer) clinical practice guidelines (version 2.2024 – May 13, 2024) recommend a variety of treatment options as recurrence therapy for platinum-resistant disease.[2] Single-agent Elahere is listed as a "preferred" targeted therapy for FRα-expressing tumors (≥ 75% positive tumor cells) (category 1) for platinum-resistant disease. Other preferred agents include cytotoxic chemotherapy (e.g., oral cyclophosphamide + bevacizumab, docetaxel, etoposide, gemcitabine, or liposomal doxorubicin) [category 2A] and targeted therapy with single-agent bevacizumab (category 2A). Elahere + bevacizumab is listed under "useful in certain circumstances" for FRα-expressing tumors (category 2A for platinum-resistant disease and category 2B for platinum-sensitive disease).

POLICY STATEMENT
Prior Authorization is recommended for prescription benefit coverage of Elahere. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Elahere as well as the monitoring required for adverse events and long-term efficacy, approval requires Elahere to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA
Coverage of Elahere is recommended in those who meet the following criteria:

FDA-Approved Indication

1. **Ovarian, Fallopian Tube, or Primary Peritoneal Cancer.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has folate receptor alpha positive disease and meets ONE of the following (i or ii):
     - **i.** Patient has ≥ 75% folate receptor alpha positive tumor cells; OR
     - **ii.** Patient is using this medication in combination with bevacizumab; AND
   - **C)** Patient has platinum-resistant disease; AND
   - **D)** The medication will be prescribed by or in consultation with an oncologist.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Elahere is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Elahere® intravenous infusion [prescribing information]. Waltham, MA: ImmunoGen; March 2024.
2. The NCCN Ovarian Cancer Including Fallopian Tube Cancer and Primary Peritoneal Cancer Clinical Practice Guidelines in Oncology (version 2.2024 – May 13, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on June 3, 2024.