BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

MEDICAL COVERAGE GUIDELINES
SECTION: DRUGS

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PROVENGE® (sipuleucel-t)

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Medical Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Medical Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Medical Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

Description:

An autologous cellular immunotherapy used for the treatment of asymptomatic or minimally symptomatic, metastatic castrate resistant (hormone-refractory), prostate cancer.

Provenge consists of specially treated dendritic cells from the individual, obtained approximately 3 days prior to each infusion date, through leukapheresis (also referred to as apheresis). Once obtained, the cells are exposed in vitro to proteins containing prostate antigens and immunologic stimulating factors. The cells are then infused back into the individual. The proposed mechanism of action is that this treatment stimulates the individual's immune system to resist spread of the cancer. Provenge is not considered an immunization.

The leukapheresis (apheresis) is performed by an apheresis or infusion facility which then sends the individual's cells to Dendreon, the manufacturer of Provenge, for processing. Dendreon returns the processed cells to the facility for administration to the individual. Provenge is administered as a series of three intravenous infusions with each infusion given about two weeks apart.

PROVENGE® (sipuleucel-t) (cont.)

Description: (cont.)

If, for any reason, the individual is unable to receive a scheduled infusion of Provenge, the Provenge dose will not be usable and the individual will need to undergo an additional leukapheresis procedure if the course of treatment is to be continued.

Criteria:

For Provenge prescribed for the treatment of cancer other than prostate cancer, see BCBSAZ Medical Coverage Guideline, *"Prescription Drugs for the Treatment of Cancer"*.

- Provenge for the treatment of men 18 years of age or older with asymptomatic **or** minimally symptomatic metastatic castrate resistant (hormone-refractory) prostate cancer is considered ***medically necessary*** with documentation of **ALL** of the following:

  1. Most recent prostate-specific antigen (PSA) level is greater than or equal to 5 ng per milliliter
  2. Most recent testosterone level is less than 50 ng per deciliter
  3. Individual is not taking opiate narcotic analgesic drugs or other potent analgesics to control pain from cancer **and** has a score of less than or equal to 7 on a 10 point visual pain scale
  4. Drug will be given in one series of 3 infusions with each infusion about 2 weeks apart[1]

[1] Only one series of up to three infusions will be covered for individuals meeting the above criteria. If an individual begins the series with another insurance provider and then becomes a BCBSAZ member, BCBSAZ will only authorize/cover the remaining number of infusions.

- Provenge for all other indications not previously listed or if above criteria not met is considered ***experimental or investigational*** based upon:

  1. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
  2. Insufficient evidence to support improvement of the net health outcome, and
  3. Insufficient evidence to support improvement of the net health outcome as much as, or more than, established alternatives, and
  4. Insufficient evidence to support improvement outside the investigational setting.

PROVENGE® (sipuleucel-t) (cont.)

Resources:

1. 8.01.53 BCBS Association Medical Policy Reference Manual. Cellular Immunotherapy for Prostate Cancer. Re-issue date 07/10/2014, issue date 05/13/2010.

2. Blue Cross and Blue Shield Association Technology Evaluation Center Evidence-based Practice Center, Mark, D, Samson D, et al. Outcomes of Sipuleucel-T Therapy Technology Assessment Report Prepared for Agency for Healthcare Research and Quality. 02/10/2011.

3. External Consultant Review. Pharmacy. 02/09/2011.

4. External Consultant Review. Pharmacy. 02/13/2011.

5. External Consultant Review. Pharmacy. 11/23/2010.

6. Kantoff PW, Higano CS, Shore ND, et al. Sipuleucel-T immunotherapy for castration-resistant prostate cancer. *N Engl J Med.* 2010;363(5):411-422.

FDA Product Approval Information for Provenge:

- FDA-approved indication: For the treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer.
- FDA-approved dosage: The recommended course of therapy for Provenge is 3 complete doses, given at approximately 2-week intervals.