Drug Coverage Policy

Effective Date 8/1/2024
Coverage Policy Number..... IP0407
Policy Title.....Proleukin for Non-Oncology Uses

Proleukin for Non-Oncology Uses

- Proleukin® (aldesleukin intravenous infusion – Prometheus Laboratories)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Cigna Healthcare Coverage Policy

Proleukin, a human recombinant interleukin-2 product, is indicated for the following:[1]

- **Metastatic melanoma**, in adults.
- **Metastatic renal cell carcinoma**, in adults.

Guidelines
Proleukin is addressed in the following National Comprehensive Cancer Network guidelines:

- **Cutaneous melanoma** (version 3.2023 – October 27, 2023) clinical practice guidelines recommend Proleukin for unresectable or metastatic disease as a single agent for second-line or subsequent therapy for disease progression or after maximum clinical benefit from BRAF targeted therapy (category 2A).[2,4] Proleukin may be considered for patients with small

brain tumors and without significant peritumoral edema (category 2B) or for intralesional therapy as primary or second-line treatment of unresectable stage III disease with clinical or satellite/in-transit metastases, or local satellite/in-transit recurrence (category 2B).

- **Hematopoietic cell transplantation** (version 3.2023 – October 9, 2023) clinical practice guidelines recommend Proleukin as additional therapy, in combination with systemic corticosteroids, for steroid-refractory chronic graft-vs-host disease.[2,5]
- **Kidney cancer** (version 2.2024 – January 3, 2024) clinical practice guidelines recommend Proleukin as a single agent for first-line (category 2B) and subsequent (category 2B) therapy for patients with relapsed or stage IV disease and clear cell histology.[2,3]

Medical Necessity Criteria

Proleukin is considered medically necessary when the following is met:

Other Uses with Supportive Evidence

1. **Graft-Versus-Host Disease**. Approve for 1 year if the patient meets the following (A, B, C, and D):
   A) Patient has chronic graft-versus-host disease; AND
   B) According to the prescriber, the patient has steroid-refractory disease; AND
   C) Proleukin will be used in combination with systemic corticosteroids; AND
   D) Proleukin will be prescribed by or in consultation with an oncologist or a physician associated with a transplant center.

   Dosing. Up to 1 million International Units/m^2 administered subcutaneously once daily.

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Conditions Not Covered

Any other use is considered experimental, investigational, or unproven (criteria will be updated as new published data are available).

Coding Information

1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
J9015	Injection, aldesleukin, per single use vial

References

1. Proleukin® intravenous infusion [prescribing information]. San Diego, CA: Prometheus Laboratories; September 2023.
2. The NCCN Drugs and Biologics Compendium. © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on January 9, 2024. Search term: aldesleukin.
3. The NCCN Kidney Cancer Clinical Practice Guidelines (version 2.2024 – January 3, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed January 9, 2024.
4. The NCCN Cutaneous Melanoma Clinical Practice Guidelines (version 3.2023 – October 27, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed January 9, 2024.
5. The NCCN Hematopoietic Cell Transplantation Clinical Practice Guidelines (version 3.2023 – October 9, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed January 9, 2024.
6. Radny P, Caroli UM, Bauer J, et al. Phase II trial of intralesional therapy with interleukin-2 in soft-tissue melanoma metastases. *Br J Cancer*. 2003;89:1620-1626.
7. Weide B, Derhovanessian E, Pflugfelder A, et al. High response rate after intratumoral treatment with interleukin-2. Results from a Phase 2 study in 51 patients with metastasized melanoma. *Cancer*. 2010;116:4139-4146.
8. Koreth J, Kim HT, Jones KT, et al. Efficacy, durability, and response predictors of low-dose interleukin-2 therapy for chronic graft-versus-host disease. *Blood*. 2016;128:130-137.

Revision Details

Type of Revision	Summary of Changes	Date
Annual Review	**Graft-Versus-Host Disease.** **Updated** initial authorization duration from 4 months to 1 year	8/1/2024

The policy effective date is in force until updated or retired.