Clinical Policy: Avelumab (Bavencio)

Reference Number: CP.PHAR.333
Effective Date: 05.01.17
Last Review Date: 02.26
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Avelumab (Bavencio®) is a programmed death ligand-1 blocking antibody.

FDA Approved Indication(s)

Bavencio is indicated for:

- Adults and pediatric patients 12 years and older with metastatic Merkel cell carcinoma (MCC).
- Maintenance treatment of patients with locally advanced or metastatic urothelial carcinoma (UC) that has not progressed with first-line platinum-containing chemotherapy.
- Patients with locally advanced or metastatic UC who:
  - Have disease progression during or following platinum-containing chemotherapy.
  - Have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.
- First-line treatment, in combination with axitinib, of patients with advanced renal cell carcinoma (RCC).

Policy/Criteria

Provider must submit documentation (including 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 Bavencio is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Merkel Cell Carcinoma (must meet all)**:**

1. Diagnosis of locally advanced, metastatic, or recurrent MCC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 12 years;
4. Request meets one of the following (a or b):*
   a. Dose does not exceed 800 mg (4 vials) every two 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:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Urothelial Carcinoma (must meet all)**:**
1. Diagnosis of recurrent, locally advanced, or metastatic UC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Member has received platinum-based chemotherapy (e.g., cisplatin, carboplatin);
5. Prescribed as a single agent;
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 800 mg (4 vials) every two 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:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

C. Renal Cell Carcinoma (must meet all)**:**
1. Diagnosis of advanced RCC (e.g., relapse, stage IV disease) with clear cell histology;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed as first-line therapy in combination with Inlyta®;
   **Prior authorization may be required for Inlyta*
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 800 mg (4 vials) every two 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:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

D. Other NCCN Recommended Uses (off-label) (must meet all)**:**
1. Diagnosis of one of the following (a-e):
   a. Gestational trophoblastic neoplasia;
   b. Endometrial carcinoma;
   c. Salivary gland tumors;
   d. Thymic carcinoma;
   e. Extranodal NK/T-cell lymphomas;
2. Prescribed or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For gestational trophoblastic neoplasia: Prescribed as a single agent following failure of ≥ 2 systemic chemotherapeutic agents (see *Appendix B*) and member has one of the following (a or b):
   a. High-risk disease;
   b. Recurrent or progressive intermediate trophoblastic tumor (placental site trophoblastic tumor or epithelioid trophoblastic tumor) following treatment with a platinum-based regimen;

5. For endometrial carcinoma, prescribed as second-line or subsequent treatment and in one of the following ways (a or b; see *Appendix B*):
   a. As a single agent for recurrent or metastatic disease for microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) tumors;
   b. In combination with Inlyta for recurrent or metastatic disease that is mismatch repair proficient (pMMR);
6. For salivary gland tumors, prescribed in combination with Inlyta for recurrent adenoid cystic carcinoma with either of the following (a or b):
   a. Distant metastases in patients with a performance status of 0-3;
   b. Unresectable locoregional recurrence or second primary with prior radiation therapy;
7. For thymic carcinoma, prescribed in combination with Inlyta* and both of the following (a and b):
   a. Disease is recurrent, advanced, or metastatic;
   b. Previous treatment or intolerability to a first-line combination therapy regimen (see *Appendix B*);

   **Prior authorization may be required for Inlyta*
8. For extranodal NK-T-cell lymphomas, prescribed for relapsed/refractory disease following additional therapy with an alternative combination chemotherapy regimen (see *Appendix B*) not previously used, if a clinical trial is unavailable;
9. Request meets one of the following (a or b):*
   a. Dose does not exceed 800 mg (4 vials) every two 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:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

E. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line

of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

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 Bavencio 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 800 mg (4 vials) every two 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:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

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 policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

dMMR: deficient mismatch repair
FDA: Food and Drug Administration

MCC: Merkel cell carcinoma
MSI-H: microsatellite instability-high
NCCN: National Comprehensive Cancer Network
pMMR: mismatch repair proficient
RCC: renal cell carcinoma
UC: urothelial carcinoma

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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Gestational Trophoblastic Neoplasia		
Examples of systemic chemotherapeutic agents: bleomycin, carboplatin, cyclophosphamide, dactinomycin, etoposide, gemcitabine, ifosfamide, mesna, methotrexate, paclitaxel, vincristine.	Varies	Varies
Endometrial carcinoma		
Examples of systemic chemotherapeutic agents: carboplatin/paclitaxel, cisplatin/doxorubicin, carboplatin/paclitaxel/bevacizumab, doxorubicin, topotecan, temsirolimus, ifosfamide	Varies	Varies
Thymic carcinoma		
Examples of systemic chemotherapeutic agents: carboplatin/paclitaxel, carboplatin/paclitaxel/ramucirumab, cyclophosphamide/doxorubicin/cisplatin/ prednisone, doxorubicin/cisplatin/ vincristine/cyclophosphamide, cisplatin/ etoposide, etoposide/ifosfamide/cisplatin	Varies	Varies
Extranodal NK/T-cell lymphomas		
Examples of systemic chemotherapeutic agents: pegaspargase/dexamethasone/ methotrexate/ifosfamide/etoposide, pegaspargase/gemcitabine/oxaliplatin, pegaspargase/dexamethasone/cisplatin/ gemcitabine, pegaspargase/methotrexate/ dexamethasone	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) 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
MCC, UC	800 mg IV infusion every 2 weeks until disease progression or unacceptable toxicity	800 mg every 2 weeks
RCC	800 mg IV infusion every 2 weeks in combination with axitinib 5 mg PO BID	800 mg every 2 weeks

VI. Product Availability

Single-dose vial: 200 mg/10 mL (20 mg/mL)

VII. References

1. Bavencio Prescribing Information. Rockland, MA: EMD Serono, Inc.; June 2025. Available at: https://www.bavencio.com/. Accessed October 23, 2025.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed November 30, 2025.
3. National Comprehensive Cancer Network. Merkel Cell Carcinoma Version 2.2026. Available at https://www.nccn.org/professionals/physician_gls/pdf/mcc.pdf. Accessed November 30, 2025.
4. National Comprehensive Cancer Network. Bladder Cancer Version 2.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/bladder.pdf. Accessed December 2, 2024.
5. National Comprehensive Cancer Network. Kidney Cancer Version 1.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf. Accessed November 30, 2025.
6. National Comprehensive Cancer Network. Gestational Trophoblastic Neoplasia Version 2.2026. Available at https://www.nccn.org/professionals/physician_gls/pdf/gtn.pdf. Accessed November 30, 2025.
7. National Comprehensive Cancer Network. Uterine Neoplasms Version 2.2026. Available at https://www.nccn.org/professionals/physician_gls/pdf/uterine.pdf. Accessed November 30, 2025.
8. National Comprehensive Cancer Network. Head and Neck Cancers Version 5.2025. Available at https://www.nccn.org/professionals/physician_gls/pdf/head-and-neck.pdf. Accessed November 30, 2025.
9. National Comprehensive Cancer Network. T-Cell Lymphomas Version 2.2025. Available at https://www.nccn.org/professionals/physician_gls/pdf/t-cell.pdf. Accessed November 30, 2025.
10. National Comprehensive Cancer Network. Thymomas and Thymic Carcinomas Version 1.2026. Available at https://www.nccn.org/professionals/physician_gls/pdf/thymic.pdf. Accessed November 30, 2025.

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
J9023	Injection, avelumab, 10 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 annual review: added criterion that Bavencio be used as single-agent therapy for urothelial carcinoma per NCCN; added endometrial carcinoma indication per NCCN; references reviewed and updated.	11.11.21	02.22
Template changes applied to other diagnoses/indications.	09.21.22	
1Q 2023 annual review: no significant changes; per NCCN added recurrent MCC as a covered indication, for gestational trophoblastic neoplasia added requirement for either high-risk disease or recurrent or progressive disease after a platinum-based regimen, and for RCC added the requirement for clear cell histology; applied standard template language and format for approval durations; references reviewed and updated.	11.22.22	02.23
1Q 2024 annual review: no significant changes; per NCCN guidelines added coverage criteria for salivary gland tumors (category 2B recommendation); references reviewed and updated.	11.28.23	02.24
1Q 2025 annual review: per NCCN guidelines added criteria for off-label use for thymic carcinoma and extranodal NK/T-cell lymphomas; for off-label use for salivary gland tumors, removed the requirement for combination use with Inlyta since Bavencio also has a 2A rec for use without Inlyta; references reviewed and updated.	12.02.24	02.25
1Q 2026 annual review: for MCC, added disease qualifier of locally advanced per NCCN; for off label indications per NCCN, revised disease qualifiers for thymic carcinoma, added option for combination with Inlyta for endometrial carcinoma, and added requirement for combination with Inlyta for salivary gland tumors; for Medicaid/HIM lines of business, revised initial approval durations from 6 months to 12 months; references reviewed and updated.	10.23.25	02.26

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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.