Clinical Policy: Duvelisib (Copiktra)

Reference Number: CP.PHAR.400
Effective Date: 10.16.18
Last Review Date: 11.26
Line of Business: Commercial, HIM/ICHRA, Medicaid Revision Log

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

Description

Duvelisib (Copiktra®) is a kinase inhibitor.

FDA Approved Indication(s)

Copiktra is indicated for the treatment of adult patients with relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) after at least two prior lines of systemic therapy.

Limitation(s) of use: Copiktra is not indicated or recommended for the treatment of any patients with CLL or SLL as initial or second line treatment due to an increased risk of treatment-related mortality.

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 Copiktra is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (must meet all)**:**

1. Diagnosis of CLL or SLL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. For brand Copiktra requests, member must use generic duvelisib, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. Disease is relapsed or refractory as evidenced by prior therapy with both of the following (a and b; *see Appendix B for examples*);*
   a. BTK inhibitor (e.g., Calquence®, Brukinsa®, Imbruvica®, Jaypirca®) ;
   b. Venclexta®;
   **Prior authorization may be required.*
6. Prescribed as a single agent;
7. Request meets one of the following (a, b, or c):*
   a. Dose does not exceed both of the following (i and ii):
      i. 50 mg per day;
      ii. 2 capsules per day;

b. Dose does not exceed 80 mg per day if co-administered with a moderate CYP3A4 inducer (*see Appendix D*);
c. 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/ICHRA – 12 months
Commercial – 12 months or duration of request, whichever is less

B. NCCN Recommended Uses (off-label) (must meet all)**:**

1. Diagnosis of one of the following (a or b):
   a. Mycosis fungoides/Sezary syndrome (MF/SS);
   b. One of the following T-cell lymphomas (i, ii, or iii):
      i. Hepatosplenic T-cell lymphoma (HSTCL) after 2 first-line therapy regimens;
      ii. Breast implant-associated anaplastic large cell lymphoma (ALCL) after at least one prior therapy;
      iii. Peripheral T-cell lymphoma (PTCL) in one of the following settings (1 or 2):
         1) Initial palliative intent therapy;
         2) After at least one prior therapy;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. For brand Copiktra requests, member must use generic duvelisib, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. Disease is relapsed or refractory;
6. Copiktra is prescribed in one of the following ways (a or b):
   a. As a single agent;
   b. In combination with romidepsin;
7. Request meets one of the following (a, b, or c):*
   a. Dose does not exceed both of the following (i and ii):
      i. 50 mg per day;
      ii. 2 capsules per day;
   b. Dose does not exceed 80 mg per day if co-administered with a moderate CYP3A4 inducer (*see Appendix D*);
   c. 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/ICHRA – 12 months
Commercial – 12 months or duration of request, whichever is less

C. 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/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, 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/ICHRA, 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 Copiktra for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For brand Copiktra requests, member must use generic duvelisib, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, request meets one of the following (a, b, or c):*
   a. New dose does not exceed both of the following (i and ii):
      i. 50 mg per day;
      ii. 2 capsules per day;
   b. New dose does not exceed 80 mg per day if co-administered with a moderate CYP3A4 inducer;
   c. 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/ICHRA – 12 months
Commercial – 12 months or duration of request, whichever is less

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/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, 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/ICHRA, 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/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALCL: anaplastic large cell lymphoma
BTK: Bruton tyrosine kinase
CLL: chronic lymphocytic leukemia
FDA: Food and Drug Administration
FL: follicular lymphoma
HSTCL: hepatosplenic T-cell lymphoma
MF: mycosis fungoides
NCCN: National Comprehensive Cancer Network
PTCL: peripheral T-cell lymphoma
SLL: small lymphocytic lymphoma
SS: Sezary syndrome

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
CLL/SLL *Examples of first-line, second-line and subsequent therapies:* • Gazyva® (obinutuzumab) ± Calquence (acalabrutinib) ± Venclexta (venetoclax) • Imbruvica (ibrutinib) ± Gazyva (obinutuzumab) or Venclexta (venetoclax) or rituximab (Rituxan, Truxima, Riabni) • Brukinsa (zanubritinib) • Jaypirca (pirtobrutinib) • Venclexta (venetoclax) ± Gazyva (obinutuzumab) or rituximab (Rituxan®, Truxima®, Riabni™)	Varies	Varies
T-cell lymphomas *Examples of first-line and subsequent therapies:* • Adcetris® (bretuximab vedotin) ± CHP (cyclophosphamide, doxorubicin, and prednisone) • CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone)	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
• CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, and prednisone) • DHA + P (dexamethasone and cytarabine + cisplatin or carboplatin or oxaliplatin) • EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, and doxorubicin) • ESHA + P (etoposide, methylprednisolone, cytarabine + cisplatin or oxaliplatin) • GDP (gemcitabine, dexamethasone, cisplatin) • GemOx (gemcitabine and oxaliplatin) • HyperCVAD (cyclophosphamide, vincristine, doxorubicin, dexamethasone) • ICE (ifosfamide, carboplatin, etoposide) • IVE (ifosfamide, etoposide, and epirubicin) • Single-agent examples: Adcetris® (bretuximab vedotin), Folotyn® (pralatrexate), Kesimpta® (alemtuzumab), Beleodaq® (belinostat), gemcitabine, bendamustine, lenalidomide, romidepsin, azacitidine, pralatrexate		

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

- Contraindication(s): none reported
- Boxed warning(s): treatment-related mortality and serious toxicities: infections, diarrhea or colitis, cutaneous reactions, and pneumonitis

Appendix D: General Information

- Examples of moderate CYP3A4 inducers include, but are not limited to: bosentan, efavirenz, etravirine, phenobarbital, and primidone.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CLL/SLL	25 mg PO BID (may reduce to 15 mg PO BID for adverse reactions). A cycle consists of 28 days If co-administered with a moderate CYP3A4 inducer: 40 mg PO BID if the initial Copiktra dose is 25 mg PO BID (25 mg PO BID if the initial Copiktra dose is 15 mg PO BID). After the inducer has been discontinued for at least 14 days, resume Copiktra at the dose taken prior to initiating the moderate CYP3A4 inducer	50 mg/day If co-administered with a moderate CYP3A4 inducer: 80 mg/day

VI. Product Availability

Capsules: 25 mg, 15 mg

VII. References

1. Copiktra Prescribing Information. Berkeley Heights, NJ: Secura Bio, Inc.; September 2025. Available at: www.copiktra.com. Accessed July 24, 2026.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed July 24, 2026.
3. National Comprehensive Cancer Network. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma Version 2.2026. Available at https://www.nccn.org/professionals/physician_gls/pdf/cll.pdf. Accessed July 24, 2026.
4. National Comprehensive Cancer Network. T-Cell Lymphomas Version 2.2026. Available at https://www.nccn.org/professionals/physician_gls/pdf/t-cell.pdf. Accessed July 24, 2026.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2022 annual review: removed off-label criteria for FL and MZL as these indications are no longer supported by NCCN; added off-label criteria for T-cell lymphomas supported by NCCN; oral oncology generic redirection language added; references reviewed and updated. Template changes applied to other diagnoses/indications.	08.02.22	11.22
4Q 2023 annual review: for off-label T-cell lymphoma indication added criterion for use as a single agent per NCCN; references reviewed and updated.	08.08.23	11.23
4Q 2024 annual review: added limitation of use per PI; for CLL/SLL, revised prior therapy requirement from at least one prior therapy to prior therapy with BTK inhibitor and Venclxta-based regimens per NCCN and PI; updated Appendix B per NCCN; clarified boxed warning language per PI; references reviewed and updated.	08.06.24	11.24
4Q 2025 annual review: for all indications, extended initial approval duration for Medicaid and HIM from 6 months to 12 months for this maintenance medication for a chronic condition; for off-label T-cell lymphomas, added option for use in combination with romidepsin per NCCN; references reviewed and updated.	07.16.25	11.25
4Q 2026 annual review: added ICHRA line of business; added off-label indication for mycosis fungoides/Sezary syndrome per NCCN; references reviewed and updated.	07.24.26	11.26

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.

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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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