Clinical Policy: Nadofaragene Firadenovec-vncg (Adstiladrin)

Reference Number: CP.PHAR.461
Effective Date: 12.16.22
Last Review Date: 11.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Coding Implications
Revision Log

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

Description

Nadofaragene firadenovec-vncg (Adstiladrin®) is a gene therapy via a non-replicating adenovirus vector harboring the human interferon alpha2b gene.

FDA Approved Indication(s)

Adstiladrin is indicated for the treatment of adult patients with high-risk, Bacillus Calmette-Guerin (BCG)-unresponsive, non-muscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors.

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

I. Initial Approval Criteria

A. Non-Muscle Invasive Bladder Cancer (must meet all)**:**

1. Diagnosis of NMIBC characterized as one of the following (a, b, or c) (*see Appendix D*):
   a. CIS only;
   b. Ta/T1 high-grade disease with concomitant CIS;
   c. Ta/T1 high-grade disease without CIS (*off-label*);
2. Prescribed by or in consultation with an oncologist or urologist;
3. Age ≥ 18 years;
4. Member is refractory to BCG* treatment (*see Appendix D)*;
   **Prior authorization may be required for BCG immunotherapy*
5. Members is not a candidate for cystectomy;
6. If request is for a dose increase, request meets one of the following (a or b):*
   a. Dose does not exceed 75 mL (4 vials) of 3 x 10^{11} viral particles (vp)/mL every 3 months;
   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: 12 months

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.

II. Continued Therapy

A. Non-Muscle Invasive Bladder Cancer (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Adstiladrin for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy as evidenced by freedom from high-grade disease recurrence, as evaluated by cytology, cystoscopy, and/or biopsy;
3. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 75 mL (4 vials) of 3 x 10^{11} vp/mL every 3 months;
   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: 12 months

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

BCG: bacillus Calmette-Guerin
CIS: carcinoma in-situ
FDA: Food and Drug Administration
NMIBC: non-muscle invasive bladder cancer
Ta/T1: description of tumor growth
Ta tumors are "papillary tumors"
T1 tumors have grown into the connective tissue of the bladder wall, but not into the muscle layer
vp: viral particles

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
Bacillus Calmette-Guerin live (TICE BCG®)	1 to 8 × 10^8 CFU (a vial) intravesical instillation once per week for 6 weeks	1 to 8 × 10^8 CFU/week

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): hypersensitivity to interferon alfa or any component of the product
- Boxed warning(s): none

Appendix D: General Information

- Refractory or "BCG unresponsive" is defined as being at least one of the following:
  1. Persistent or recurrent CIS alone or with recurrent Ta/T1 disease within 12 months of completion of adequate BCG therapy, defined as at least one of the following:
     a. At least 5 of 6 doses of an initial induction course plus at least 2 of 3 doses of maintenance therapy;
     b. At least 5 of 6 doses of an initial induction course plus at least 2 of 6 doses of the second induction course;
  2. Recurrent high-grade Ta/T1 disease within 6 months of completion of adequate BCG therapy;
  3. T1 high-grade disease at the first evaluation following an induction BCG course.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
High grade, BCG unresponsive NMIBC	Initial dose: 1 x 10^{11} vp/mL OR 3 x 10^{11} vp/mL Retreatment at months 4, 7, and 10	75 mL (4 vials) of 3 x 10^{11} vp/mL for a total of four doses

VI. Product Availability

Single-use vial: 3 x 10^{11} vp/mL; four single-dose vials per carton

VII. References

1. Adstiladrin Prescribing Information. Kuopio, Finland. Ferring Pharmaceuticals. March 2026. Available at https://www.adstiladrinhcp.com/. Accessed July 22, 2026.
2. Boorjian SA, Alemozaffar M, Bad Konety BR, et al. Intravesical nadofaragene firadenovec gene therapy for BCG-unresponsive non-muscle-invasive bladder cancer: a single-arm, open-label, repeat-dose clinical trial. *Lancet Oncol*. doi: 10.1016/S1470-2045(20)30540-4.
3. National Comprehensive Cancer Network. Bladder Cancer Version 2.2026. Available at https://www.nccn.org/professionals/physician_gls/pdf/bladder.pdf. Accessed July 22, 2026.
4. Holzbeierlein J, Bixler BR, Buckley DI, et al. Diagnosis and treatment of non-muscle invasive bladder cancer: AUA/SUO guideline: 2024 amendment. *J Urol.* 2024;10.1097/JU.0000000000003846.
5. Shore ND, Boorjian SA, Canter DJ, et al. Intravesical rAD-IFNα/Syn3 for patients with high-grade, Bacillus Calmette-Guerin refractory or relapsed nonmuscle-invasive bladder cancer: a phase II randomized study. *Journal of Clinical Oncology.* August 2017; 35(30): 3410-3416.
6. Narayan VM, Boorjian SA, Alemozaffar M, et al. Efficacy of intravesical nadofaragene firadenovec for patients with bacillus calmette-guérin-unresponsive nonmuscle-invasive bladder cancer: 5-year follow-up from a phase 3 trial. *J Urol.* 2024 Jul;212(1):74-86. doi: 10.1097/JU.0000000000004020.

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
J9029	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2023 annual review: RT1: drug is now FDA approved - policy updated per FDA labeling without significant changes to criteria; references reviewed and updated.	01.18.23	02.23
Added HCPCS code [J9029]	05.24.23	
1Q 2024 annual review: removed initial criteria requirement for clinically significant elevated liver or renal function tests per	10.27.23	02.24

Reviews, Revisions, and Approvals	Date	P&T Approval Date
prescribing information; added oncology dosing criteria to allow doses supported by practice guidelines or literature; removed category 2B NCCN recommendation: NMIBC characterized by Ta/T1 high-grade without concomitant CIS per NCCN; removed HCPCS code J3590 and C9399; references reviewed and updated.		
Revised HCPCS code description [J9029]	03.11.24	
4Q 2024 annual review: added option for prescribed by or in consultation with an urologist; added off-label indication for Ta/T1 high-grade disease without CIS per NCCN; removed requirement for intravesical chemotherapy per NCCN; added requirement that member is not a candidate for cystectomy; increased approval duration from 3 months to 6 months; references reviewed and updated	08.13.24	11.24
4Q 2025 annual review: no significant changes; references reviewed and updated.	07.22.25	11.25
Removed lifetime dose requirement, clarified frequency does not exceed every 3 months, removed specification of "a single dose". Added ICHRA line of business.	03.31.26	05.26
4Q 2026 annual review: increased initial and continued therapy approval duration to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.	07.22.26	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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