Clinical Policy: Nogapendekin Alfa Inbakicept-pmln (Anktiva)

Reference Number: CP.PHAR.684
Effective Date: 09.01.24
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

Nogapendekin alfa inbakicept-pmln (Anktiva®) is an interleukin-15 (IL-15) receptor agonist.

FDA Approved Indication(s)

Anktiva is indicated in combination with Bacillus Calmette-Guérin (BCG) for the treatment of adult patients with BCG-unresponsive, non-muscle invasive bladder cancer (NMIBC).

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 Anktiva 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 NIMBC characterized as one of the following (a, b, or c):
   a. Carcinoma in situ (CIS) only;
   b. Ta/T1 high-grade disease with concomitant CIS;
   c. Ta/T1 high-grade disease without CIS;
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. Provider attestation that Adstiladrin® therapy has been considered and not recommended (provider must submit clinical rationale supporting use of Anktiva over Adstiladrin);
7. Anktiva is prescribed in combination with BCG;
8. Request meets one of the following (a or b):*
   a. Dose does not exceed 400 mcg (1 vial) per week;
   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 Anktiva for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy as evidenced by lack of disease recurrence or progression;
3. Total treatment duration does not exceed 37 months;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 400 mcg (1 vial) per week for up to a total of 24 doses;
   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-Guérin
CIS: carcinoma in situ
FDA: Food and Drug Administration
IL: interleukin
NCCN: National Comprehensive Cancer Network
NMIBC: non-muscle invasive bladder cancer

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 x 10^8 CFU (a vial) intravesical instillation once per week for 6 weeks	1 to 8 x 10^8 CFU per 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

None reported

Appendix D: General Information

- Refractory or "BCG unresponsive" is defined as being at least one of the following:
  1. Persistent or recurrent CIS alone and/or 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 initial induction course plus at least 2 of 6 doses of the second induction course

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
NMIBC	Induction: 400 mcg administered intravesically with BCG once weekly for 6 weeks. A second induction course may	400 mcg/week

Indication	Dosing Regimen	Maximum Dose
	be administered if patients have residual CIS and/or high-grade Ta tumors at month 3. Maintenance: 400 mcg administered intravesically with BCG once a week for 3 weeks at months 4, 7, 10, 13 and 19 (with possible addition of once weekly administrations for 3 weeks at months 25, 31, and 37 for patients with no evidence of high-grade disease at month 25) Maximum treatment duration of 37 months	

VI. Product Availability

Single dose vial: 400 mcg/0.4mL

VII. References

1. Anktiva Prescribing Information. Bothell, WA: AGC Biologics; October 2026. Available at https://www.anktiva.com/. Accessed October 20, 2026.
2. Chamie K, Chang SS, Kramolowsky E, et al. IL-15 Superagonist NAI in BCG-Unresponsive Non-Muscle-Invasive Bladder Cancer. *NEJM Evid*. 2023; 2(1):EVIDoa2200167.
3. Chamie K, Chang SS, Kramolowsky EV, et al. Quality of life in the phase 2/3 trial of N-803 plus Bacillus Calmette-Guérin in Bacillus Calmette-Guérin–unresponsive nonmuscle-invasive bladder cancer. *Urol Pract*. 2024 Mar;11(2):367-375. doi: 10.1097/UPJ.0000000000000517.
4. 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.

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
J9028	Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	05.20.24	08.24
HCPCS code added [J9028] and removed codes [J9999, C9399].	11.07.24	
3Q 2025 annual review: no significant changes; removed irrelevant drugs from Appendix B; references reviewed and updated.	05.13.25	08.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2026 annual review: added ICHRA line of business; added off-label indication for Ta/T1 high-grade disease without CIS per NCCN; added option to be prescribed by or in consultation with an urologist; added requirement that member is not a candidate for cystectomy per NCCN; references reviewed and updated. Per June SDC, added requirement for provider attestation that Adstiladrin therapy has been considered and not recommended with clinical rationale supporting Anktiva over Adstiladrin.	06.09.26	08.26
4Q 2026 annual review: extended initial approval duration from 6 months to 12 months for this chronic condition; references reviewed and updated. RT4: updated per FDA label expansion to include BCG-unresponsive NMIBC without CIS (i.e., with high-grade papillary-only tumors).	10.20.26	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.

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.

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