Reference number(s)
1680-A

SPECIALTY GUIDELINE MANAGEMENT

IMLYGIC (talimogene laherparepvec)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications
Imlygic is indicated for the local treatment of unresectable cutaneous, subcutaneous, and nodal lesions in patients with melanoma recurrent after initial surgery.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Melanoma
Authorization of 12 months may be granted for treatment of melanoma.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Imlygic [package insert]. Thousand Oaks, CA: Amgen Inc.; August 2017.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed November 28, 2017.
3. The NCCN Clinical Practice Guidelines in Oncology™ Melanoma (Version 1.2018). ©2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed November 28, 2017.