Reference number(s)
2080-A

SPECIALTY GUIDELINE MANAGEMENT

PROLEUKIN (aldesleukin)

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.

A. FDA-Approved Indications[1]
   1. Metastatic renal cell carcinoma in adults
   2. Metastatic melanoma in adults

B. Compendial Uses[2]
   1. Relapsed or stage IV surgically unresectable kidney cancer with clear cell histology
   2. Metastatic or unresectable melanoma

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

II. CRITERIA FOR INITIAL APPROVAL

A. Renal Cell Carcinoma
Authorization of 12 months may be granted for treatment of relapsed, metastatic, or unresectable renal cell carcinoma.

B. Melanoma
Authorization of 12 months may be granted for treatment of metastatic or unresectable 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. Proleukin [package insert]. San Diego, CA: Prometheus Laboratories Inc.; January 2015.
2. The NCCN Drugs & Biologic Compendium® © 2018 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed May 8, 2018.