

**Clinical Policy: Copanlisib (Aliqopa)**

Reference Number: CP.PHAR.357

Effective Date: 12.01.17

Last Review Date: 11.23

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)  
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

**Description**

Copanlisib (Aliqopa<sup>®</sup>) is a phosphatidylinositol-3-kinase inhibitor.

**FDA Approved Indication(s)**

Aliqopa is indicated for the treatment of adult patients with relapsed follicular lymphoma (FL) who have received at least two prior systemic therapies.\*

---

*\*Accelerated approval was granted for this indication based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.*

**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<sup>®</sup> that Aliqopa is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria****A. Follicular and Other B-Cell Lymphomas (must meet all):**

1. Diagnosis of one of the following B-cell lymphoma subtypes (a or b):
  - a. FL;
  - b. Marginal zone lymphoma (off-label) (i, ii, or iii):
    - i. Splenic marginal zone lymphoma;
    - ii. Nodal marginal zone lymphoma;
    - iii. Extranodal marginal zone lymphoma (a or b):
      - a) Gastric MALT lymphoma;
      - b) Nongastric MALT lymphoma;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age  $\geq$  18 years;
4. Relapsed/refractory disease after  $\geq$  2 prior therapies (*see Appendix B for examples*);\*  
*\*Prior authorization may be required*
5. Request meets one of the following (a or b):\*
  - a. Dose does not exceed 60 mg (1 vial) per week for 3 out of 4 weeks;
  - 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:****Medicaid/HIM – 6 months**

**Commercial** – 6 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) 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, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) 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, 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, and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Follicular and Other B-Cell Lymphomas** (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Aliqopa for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following\* (a or b):
  - a. New dose does not exceed 60 mg (1 vial) per week for 3 out of 4 weeks;
  - 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:**

**Medicaid/HIM** – 12 months

**Commercial** – 6 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) 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, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business:

**CLINICAL POLICY**  
**Copanlisib**

CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, 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, 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 policy – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

FL: follicular lymphoma

NCCN: National Comprehensive Cancer Network

*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 |
|--|----------------|--------------------------|
| <p><b>Follicular Lymphoma</b><br/><i>Examples of first-line, second-line and subsequent therapies:</i></p> <ul style="list-style-type: none"> <li>• bendamustine + Gazyva<sup>®</sup> (obinutuzumab) or rituximab</li> <li>• CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) + Gazyva or rituximab</li> <li>• CVP (cyclophosphamide, vincristine, prednisone) + Gazyva or rituximab</li> <li>• <u>Single-agent examples:</u> rituximab; Revlimid<sup>®</sup> (lenalidomide) ± rituximab</li> </ul> | Varies         | Varies                   |
| <p><b>Marginal Zone Lymphomas</b><br/><i>Examples of first-line, second-line and subsequent therapies:</i></p> <ul style="list-style-type: none"> <li>• bendamustine + rituximab, bendamustine + Gazyva<sup>®</sup></li> <li>• RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone)</li> <li>• RCVP (rituximab, cyclophosphamide, vincristine, prednisone)</li> </ul>   | Varies         | Varies                   |

| Drug Name  | Dosing Regimen | Dose Limit/ Maximum Dose |
|--|----------------|--------------------------|
| <ul style="list-style-type: none"> <li>Single-agent examples: rituximab; Leukeran<sup>®</sup> (chlorambucil) ± rituximab; cyclophosphamide ± rituximab; Imbruvica<sup>®</sup> (ibrutinib); Revlimid ± rituximab; Copiktra<sup>®</sup> (duvelisib); Zydelig<sup>®</sup> (idelalisib)</li> </ul> |                |                          |

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

*Appendix C: Contraindications/Boxed Warnings*

None reported

**V. Dosage and Administration**

| Indication | Dosing Regimen  | Maximum Dose    |
|------------|---|-----------------|
| FL         | 60 mg IV on Days 1, 8, and 15 of a 28-day treatment cycle on an intermittent schedule (3 weeks on/1 week off) | 60 mg/dose/week |

**VI. Product Availability**

Single-dose vial: 60 mg

**VII. References**

1. Aliqopa Prescribing Information. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; March 2023. Available at: [www.aliqopa.com](http://www.aliqopa.com). Accessed June 30, 2023.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at [www.nccn.org](http://www.nccn.org). Accessed July 10, 2023.
3. National Comprehensive Cancer Network. B-Cell Lymphomas Version 5.2023. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/b-cell.pdf](https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf). July 10, 2023.

**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                 |
|-------------|-----------------------------|
| J9057       | Injection, copanlisib, 1 mg |

| Reviews, Revisions, and Approvals   | Date     | P&T Approval Date |
|---|----------|-------------------|
| 4Q 2019 annual review: NCCN recommended B-cell lymphoma subtypes added - Appendix B required therapy examples expanded accordingly; relapsed or refractory disease added; dosing detail - 3 | 08.27.19 | 11.19             |

| Reviews, Revisions, and Approvals  | Date     | P&T Approval Date |
|--|----------|-------------------|
| out of 4 weeks - added per PI; FDA/NCCN dosing limitation added; references reviewed and updated.  |          |                   |
| 4Q 2020 annual review: added Commercial line of business; no significant changes; references reviewed and updated.   | 07.13.20 | 11.20             |
| 4Q 2021 annual review: no significant changes; revised HIM-Medical Benefit to HIM; references reviewed and updated.  | 08.06.21 | 11.21             |
| 4Q 2022 annual review: no significant changes; references reviewed and updated. Template changes applied to other diagnoses/indications.   | 08.02.22 | 11.22             |
| 4Q 2023 annual review: no significant changes; revised commercial line of business approval duration to “6 months or duration of request, whichever is less”; references reviewed and updated. | 06.30.23 | 11.23             |

**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.

**CLINICAL POLICY**  
Copanlisib

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.

©2017 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene<sup>®</sup> and Centene Corporation<sup>®</sup> are registered trademarks exclusively owned by Centene Corporation.