

Penpulimab-KCQX (penpulimab-kcqx) (Intravenous)

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I. Length of Authorization ^{Δ 1,13}

- Initial: Prior authorization validity will be provided initially for 6 months (180 days).
- Renewal: Prior authorization validity may be renewed every 6 months (180 days) thereafter up to a maximum of 24 months (35 or 52 total doses based on regimen).

II. Dosing Limits

Max Units (per dose and over time) [HCPCS Unit]:

- 200 mg every 2 weeks

III. Initial Approval Criteria ¹

Prior authorization validity is provided in the following conditions:

- Member is at least 18 years of age; **AND**

Universal Criteria ^{1,2}

- Member has not received previous therapy with a programmed death (PD-1/PD-L1)-directed therapy, unless otherwise specified ^Δ; **AND**

Head and Neck Cancers † ± Φ ¹⁻⁵

- Member has non-keratinizing disease; **AND**
 - Member has Cancer of the Nasopharynx; **AND**
 - Used as first-line therapy †; **AND**
 - Member has metastatic OR recurrent disease; **AND**
 - Used in combination with either cisplatin or carboplatin and gemcitabine; **OR**
 - Used as subsequent therapy; **AND**
 - Used as single-agent therapy †; **AND**
 - Member has recurrent metastatic disease; **AND**
 - Member experienced disease progression on or after a platinum-containing chemotherapy regimen and at least one other prior line of therapy

Preferred therapies and recommendations are determined by review of clinical evidence. NCCN category of recommendation is taken into account as a component of this review. Regimens deemed equally efficacious (i.e., those having the same NCCN categorization) are considered to be therapeutically equivalent.

Enhanced Oncology Value (EOV) Program – Redacted indications

Uses not listed above have inadequate data to support efficacy and are excluded from prior authorization validity.

Other treatment options including, but are not limited to, the following may be appropriate: radiation therapy, surgery, traditional chemotherapy (e.g., platinum, taxane), compassionate use/expanded access programs, clinical trials, supportive care, integrative and complementary therapies.

❖ If confirmed using an FDA approved assay – <http://www.fda.gov/CompanionDiagnostic>

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); Ⓢ Orphan Drug

IV. Renewal Criteria ^{Δ 1,4,5}

Prior authorization validity may be renewed based upon the following criteria:

- Member continues to meet the universal and other indication-specific relevant criteria identified in section III; **AND**
- Duration of authorization has not been exceeded (*refer to Section I*); **AND**
- Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe immune-mediated adverse reactions (e.g., pneumonitis, hepatotoxicity and hepatitis, colitis, endocrinopathies, nephritis with renal dysfunction, dermatologic adverse reactions/rash, etc.), severe infusion-related reactions, complications of allogeneic hematopoietic stem cell transplantation (HSCT), etc.

^Δ Notes:

- Members responding to therapy who relapse ≥ 6 months after discontinuation due to duration (i.e., receipt of 24 months of therapy) are eligible to re-initiate PD-directed therapy.
- Members previously presenting with aggressive disease who are exhibiting stable disease on treatment as their best response (or if therapy improved performance status) may be eligible for continued therapy beyond the 24-month limit without interruption or discontinuation.
- Members who complete adjuvant therapy and progress ≥ 6 months after discontinuation are eligible to re-initiate PD-directed therapy for metastatic disease.

V. Dosage/Administration ^{Δ 1,9,12-15}

Indication	Dose
Head and Neck Cancers	<u>Combination therapy</u> Administer 200 mg intravenously every three weeks until disease progression or unacceptable toxicity, or up to 24 months. <u>Single-agent therapy</u> Administer 200 mg intravenously every two weeks until disease progression or unacceptable toxicity, or up to 24 months.

VI. Billing Code/Availability Information

HCPCS Code:

- J9999 – Not otherwise classified, antineoplastic drugs

NDC:

- Penpulimab-kcqx 100 mg/10 mL (10 mg/mL) single-dose vial: 83654-0105-xx

VII. References (STANDARD)

1. Penpulimab-kcqx [package insert]. Guangdong, China; Akeso Biopharma Co., Ltd.; April 2025. Accessed April 2026.
2. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) penpulimab-kcqx. National Comprehensive Cancer Network, 2026. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed April 2026.
3. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) Head and Neck Cancers. Version 1.2026. National Comprehensive Cancer Network, 2026. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed April 2026.
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VIII. References (ENHANCED)

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Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist

Non-quantitative treatment limitations (NQTLs) refer to the methods, guidelines, standards of evidence, or other conditions that can restrict how long or to what extent benefits are provided under a health plan. These may include things like utilization review or prior authorization. The utilization management NQTL applies comparably, and not more stringently, to mental health/substance use disorder (MH/SUD) Medical Benefit Prescription Drugs and medical/surgical (M/S) Medical Benefit Prescription Drugs. The table below lists the factors that were considered in designing and applying prior authorization to this drug/drug group, and a summary of the conclusions that Prime’s assessment led to for each.

Factor	Conclusion
Indication	Yes: Consider for PA
Safety and efficacy	No: PA not a priority
Potential for misuse/abuse	No: PA not a priority
Cost of drug	Yes: Consider for PA

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
C11.0	Malignant neoplasm of superior wall of nasopharynx
C11.1	Malignant neoplasm of posterior wall of nasopharynx
C11.2	Malignant neoplasm of lateral wall of nasopharynx
C11.3	Malignant neoplasm of anterior wall of nasopharynx
C11.8	Malignant neoplasm of overlapping sites of nasopharynx
C11.9	Malignant neoplasm of nasopharynx, unspecified
C14.0	Malignant neoplasm of pharynx, unspecified
C14.2	Malignant neoplasm of Waldeyer’s ring
C30.0	Malignant neoplasm of nasal cavity
C31.0	Malignant neoplasm of maxillary sinus
C31.1	Malignant neoplasm of ethmoidal sinus
D37.05	Neoplasm of uncertain behavior of pharynx
D38.5	Neoplasm of uncertain behavior of other respiratory organs
D38.6	Neoplasm of uncertain behavior of respiratory organ, unspecified
Z85.818	Personal history of malignant neoplasm of other sites of lip, oral cavity, and pharynx

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: <https://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC