

Kaiser Foundation Health Plan of Washington
Kaiser Foundation Health Plan of Washington Options, Inc.
 Provider Communications, RCR-A3W-04
 PO Box 34262, Seattle WA 98124-1262

December 30, 2025

ONCOLOGY PRODUCTS UPDATED PRIOR AUTHORIZATION CRITERIA

Dear Provider,

Effective March 1, 2026, the criteria for the oncology products in Table 1 will be updated to include quantity limits. These products are on the **non-Medicare** list of office-administered drugs requiring prior authorization. **This letter serves as notification of upcoming changes to coverage for these medications under the medical benefit.**

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington, Options, Inc. require prior authorization for a select group of injectable drugs that may be administered under the medical benefit in a physician's office or by home infusion. These reviews are intended to ensure consistent benefit adjudication as well as appropriate utilization in accordance with the Kaiser Permanente Pharmacy & Therapeutics Committee's evidence-based criteria for coverage.

Table 1. List of Oncology Products that have prior authorization criteria:

BRAND NAME	GENERIC NAME	HCPCS
Bavencio	Avelumab	J9023
Imdelltra	Tarlatamab-dlle	J9026, C9170
Loqtorzi	Toripalimab-tpzi	J3263
Tevimbra	Tislelizumab	J9329
Zynzyz	Retifanlimab-dlwr	J9345

Quantity Limit Addition for Oncology Products in Table 1 (changes are in bold):

DRUG NAME	COVERAGE CRITERIA
AVELUMAB	Quantity Limit: <ul style="list-style-type: none"> Avelumab authorizations for all indications will be limited to 1 year. Requests for an additional year of therapy will require documentation of disease stability (lack of progression).
TARLATAMAB-DLLE	Quantity Limit: <ul style="list-style-type: none"> Tarlatamab authorizations for all indications will be limited to 1 year. Requests for an additional year of therapy will require documentation of disease stability (lack of progression).
TORIPALIMAB-TPZI	Quantity Limit: <ul style="list-style-type: none"> Toripalimab authorizations for all indications will be limited to 1 year. Requests for an additional year of therapy will require documentation of disease stability (lack of progression).
TISLELIZUMAB	Quantity Limit:

	<ul style="list-style-type: none"> Tislelizumab authorizations for all indications will be limited to 1 year. Requests for an additional year of therapy will require documentation of disease stability (lack of progression).
RETIFANLIMAB-DLWR	<p>Quantity Limit:</p> <ul style="list-style-type: none"> Retifanlimab authorizations for all indications will be limited to 1 year. Requests for an additional year of therapy will require documentation of disease stability (lack of progression).

Additional Information

A complete list of office-administered injectable drugs requiring prior authorization can be found on the Kaiser Permanente provider website at

<https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/officeinject>.

To request prior authorization review, please use the Referral Request online form (login required) located on the Kaiser Permanente provider website. You can also fax your request to the Review Services department toll-free at 1-888-282-2685.

Thank you for the care you provide to our members, your patients. If you have any questions about this process, please call Review Services at 1-800-289-1363, Monday through Friday, from 8:00 a.m. to 5:00 p.m.

Sincerely,



Ravi Ubriani, MD, Chair
Pharmacy & Therapeutics Committee