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Kaiser Foundation Health Plan of Washington Options, Inc.
Provider Communications, RCR-A3W-04
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August 29, 2025

ONCOLOGY PRODUCTS UPDATED PRIOR AUTHORIZATION CRITERIA

Dear Provider,

Effective December 1, 2025, 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. Additionally, cetuximab (Erbitux) will be added to 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.(Kaiser Permanente) 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
Tecentriq	Atezolizumab	J9022
Darzalex	Daratumumab	J9145
Darzalex Faspro	Daratumumab/hyaluronidase-fihj	J9144
Imfinzi	Durvalumab	J9173
Padcev	Enfortumab vedotin-ejfv	J9177
Yervoy	Ipilimumab	J9228
Sarclisa	Isatuximab-irfc	J9227
Zynyz	Retifanlimab-dlwr	J9345
Imjudo	Tremelimumab-actl	C9147, J9347

Prior Authorization Criteria for Oncology Products in Table 1 (changes are in bold):

DRUG NAME	COVERAGE CRITERIA
ATEZOLIZUMAB	**Quantity Limit:** • **Authorizations for all indications will be limited to 1 year. Requests for an additional year of therapy in the palliative (non-curative) setting will require documentation of disease stability (lack of progression).**
DARATUMUMAB	**Quantity Limit:** • **The approved maximum dose of 16 mg/kg will be rounded down to a dose consistent with the lowest vial size combination to minimize waste when the resulting reduction is less than 10% of the maximum allowed dose**
DARATUMUMAB/HYALURONIDASE-FIHJ	**Quantity Limit:** • **1800 mg per 28 days**

DURVALUMAB	**Quantity Limit:** • **Authorizations for all indications will be limited to 1 year. Requests for an additional year of therapy in the palliative (non-curative) setting will require documentation of disease stability (lack of progression).**
ENFORTUMAB VEDOTIN-EJFV	**Quantity Limit:** • **The approved weekly dose of 1.25 mg/kg will be rounded down to a dose consistent with the lowest vial size combination to minimize waste when the resulting reduction is less than 10% of the maximum allowed dose**
IPILIMUMAB	**Quantity Limit:** • **The approved maximum dose of 3 mg/kg will be rounded down to a dose consistent with the lowest vial size combination to minimize waste when the resulting reduction is less than 10% of the maximum allowed dose**
ISATUXIMAB-IRFC	**Quantity Limit:** • **The approved dose of 10 mg/kg will be rounded down to a dose consistent with the lowest vial size combination to minimize waste when the resulting reduction is less than 10% of the maximum allowed dose**
RETIFANLIMAB-DLWR	**Quantity Limit:** • **Coverage restricted to a total of 12 cycles**
TREMELIMUMAB-ACTL	**Quantity Limit:** • **Authorizations for all indications will be limited to 1 year. Requests for an additional year of therapy in the palliative (non-curative) setting will require documentation of disease stability (lack of progression).**

Prior Authorization Criteria for Cetuximab (Erbitux) J9055 (changes are in bold):

DRUG NAME	COVERAGE CRITERIA
CETUXIMAB	**Approved for all FDA indications.** **Quantity Limits:** • **Authorizations for all indications will be limited to a maximum maintenance dose: IV: 250 mg/m^2 every week or 500 mg/m^2 every 2 weeks, with the approved dose to be rounded down to the nearest vial size when the resulting reduction is less than 10% of the maximum allowed dose.** • **Authorizations for all indications will be limited to 1 year. Requests for an additional year of therapy in the palliative (non-curative) setting 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