

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

May 29, 2026

ONCOLOGY PRODUCTS UPDATED PRIOR AUTHORIZATION CRITERIA

Dear Provider,

Effective September 1, 2026, the quantity limit for the oncology products in Table 1 will be updated. These products are on the **non-Medicare** list of office-administered drugs requiring prior authorization. **This letter is a notification of the upcoming changes in 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:

BRAND NAME	GENERIC NAME	HPCS
Enhertu	Fam-trastuzumab deruxtecan-nxki	J9358
Yervoy	Ipilimumab	J9228

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

DRUG NAME	COVERAGE CRITERIA
FAM-TRASTUZUMAB DERUXTECAN-NXKI	Quantity Limit: <ul style="list-style-type: none"> • Breast cancer: authorizations will be limited to a maximum dose of 6.4 mg/kg* every 21 days for 1 year. • Breast cancer: All authorizations will be limited to a maximum dose of 5.4 mg/kg* every 21 days for 1 year. • Gastric cancer: authorizations will be limited to a maximum dose of 6.4 mg/kg* every 21 days for 1 year. • Requests for continuation of therapy will require documentation of disease stability (lack of progression). • *The approved dose will be rounded down to the nearest vial size when the resulting reduction is less than 10% of the maximum allowed dose.
IPILIMUMAB	Melanoma: <ol style="list-style-type: none"> 1. Patients with unresectable or metastatic melanoma. <ul style="list-style-type: none"> ○ Cover for a max of 4 doses at 1 3 mg/kg. ○ Do not cover 10 mg/kg dose or maintenance therapy. 2. Treatment of patients with stage IIB, IIC, or III in the adjuvant setting, after previous PD-1 inhibitor. <ul style="list-style-type: none"> ○ Cover for a max of 4 doses at 1 3 mg/kg. ○ Do not cover 10 mg/kg dose or maintenance therapy 3. Covered for neoadjuvant treatment of stage III Melanoma if all of the following apply: <ul style="list-style-type: none"> ○ One or more Lymph nodes AND ○ 3 or less in-transit Metastasis AND

- Combined with Nivolumab AND followed by Nivolumab for adjuvant treatment if greater than 10% viable tumor.

Uveal Melanoma:

4. Covered for the treatment of patients with uveal melanoma:
 - For widely metastatic disease,
 - If combined with nivolumab AND
 - If patient is tebentafusp ineligible

Non-small cell lung cancer (NSCLC):

5. Treatment of patients with advanced-stage NSCLC who:
 - Exhibit PD-L1 expression AND
 - Combine treatment with Nivolumab AND
 - Have not previously been treated with PD-1 immunotherapy agents.

Renal Cell Carcinoma:

6. In combination with nivolumab for advanced clear-cell renal cell carcinoma
7. In combination with nivolumab for previously untreated metastatic non-clear cell, sarcomatoid renal cell carcinoma.

Mesothelioma:

8. Covered for locally advanced unresectable mesothelioma if combined with nivolumab.

Hepatocellular Carcinoma (HCC):

9. Treatment of hepatocellular carcinoma if ALL the following apply:
 - Combined with nivolumab
 - Child Pugh A
 - Immunotherapy naïve
 - Contraindication to atezolizumab with bevacizumab

Colorectal Cancer:

10. Treatment of stage IV colorectal cancer that is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) if:
 - Patients who are immunotherapy naïve AND
 - Combined with nivolumab

Note: If progression noted off immuno-oncology (IO) therapy after completion of 2 years of therapy, may restart utilizing first-line IO therapy options.

11. For patients with locoregionally advanced colorectal cancer, as neoadjuvant treatment, if:
 - Microsatellite instability-high (MSIH) or mismatch repair deficient (dMMR)
 - Patients who are immunotherapy naïve
 - Combined with nivolumab
 - Limited to one year total therapy.

Gastric Cancer/GEJ:

12. Covered as peri-operative/neoadjuvant treatment of Gastric Cancer/GEJ Siewert III:
 - If planned Lymphadenectomy AND
 - If combined with Nivolumab AND
 - dMMR/MSI-H tumor

Quantity Limit:

- The approved maximum dose of **31** 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
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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 for 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