Corporate Medical Policy: Lifileucel (Amtagvi®) **"Notification"** **POLICY EFFECTIVE APRIL 1, 2026**

Restricted Product(s):

- lifileucel (Amtagvi®) intravenous infusion for administration by a healthcare professional

FDA Approved Use:

- For the treatment of adults with unresectable or metastatic melanoma previously treated with a PD-1 blocking antibody, and if BRAF V600 mutation positive, a BRAF inhibitor with or without a MEK inhibitor.

Criteria for Medical Necessity:

The restricted product(s) may be considered medically necessary when the following criteria are met:

1. The patient is 18 years of age or older; **AND**
2. The patient has a diagnosis of **unresectable or metastatic melanoma [medical record documentation required]**; **AND**
3. The patient does NOT have uveal or ocular melanoma **[medical record documentation required]**; **AND**
4. The patient has experienced disease progression despite treatment with a programmed cell death protein-1 (PD-1) blocking antibody **[medical record documentation required]**; **AND**
5. If the patient is proto-oncogene B-Raf (BRAF) V600 mutation-positive, the patient has tried and had an inadequate response to a BRAF inhibitor with or without a mitogen-activated extracellular signal-regulated kinase (MEK) inhibitor **[medical record documentation required]**; **AND**
6. The patient has received or will receive lymphodepleting chemotherapy prior to infusion with the requested agent **[medical record documentation required]**; **AND**
7. The patient is deemed eligible for IL-2 (aldesleukin) therapy **[medical record documentation required]**; **AND**
8. Patient does NOT have uncontrolled brain metastases **[medical record documentation required]**; **AND**
9. The patient does NOT have signs and symptoms of acute renal failure prior to treatment **[medical record documentation required]**; **AND**
10. The patient does NOT have hemorrhage (grade 2 or higher) within 14 days prior to treatment **[medical record documentation required]**; **AND**
11. The patient does NOT have a left ventricular ejection fraction (LVEF) less than 45% or New York Heart Association (NYHA) functional classification greater than Class 1 **[medical record documentation required]**; **AND**
12. The patient does NOT have a forced expiratory volume in one second (FEV1) of less than or equal to 60% **[medical record documentation required]**; **AND**
13. The patient does NOT have a clinically significant active systemic infection **[medical record documentation required]**; **AND**

14. The patient has NOT previously received genetically modified T cell therapy or lifileucel (Amtagvi) **[medical record documentation required]**; **AND**
15. The patient will NOT receive concomitant prophylactic systemic corticosteroid therapy **[medical record documentation required]**; **AND**
16. The patient will NOT be treated with more than 72 x 10^9 viable T cells **[documentation of planned dosage required]**.

Duration of Approval: 180 days (one treatment course per lifetime)

** Please note, for certain identified gene and cellular therapies such as lifileucel (Amtagvi®), when coverage is available and the individual meets medically necessary criteria, distribution from a specialty pharmacy provider due to cost (distribution channel restriction) may be required in order for coverage to be provided. **Please contact Blue Cross NC** to coordinate this therapy.

FDA Label Reference				
Medication	**Indication**	**Dosing**	**HCPCS**	**Maximum Units***
lifileucel (Amtagvi®) intravenous (IV) infusion	Unresectable or metastatic melanoma	Dose is between 7.5 x 10^9 and 72 x 10^9 viable cells	C9399** J3490** J3590** J9999**	**1** (one treatment course)

***Maximum units allowed for duration of approval**
****Non-specific assigned HCPCS codes, must submit requested product NDC**

Other revenue codes that may be applicable to this policy: 0891, 0892

References: all information referenced is from FDA package insert unless otherwise noted below.

Policy Implementation/Update Information: Criteria and treatment protocols are reviewed annually by the Blue Cross NC P&T Committee, regardless of change. This policy is reviewed in Q3 annually.

April 2026: Coding change: Added the following applicable revenue codes associated with policy HCPCS code(s): 0891 (Special Processed Drugs – FDA Approved Cell Therapy) and 0892 (Special Processed Drugs – FDA Approved Gene Therapy). **Policy notification given 2/1/2026 for effective date 4/1/2026**.

December 2025: Criteria update: Minor formatting updates with no change to intent. Added Gene/Cellular Therapy distribution channel management language according to benefit booklet for clarity.
May 2024: Original medical policy criteria issued.