

Clinical Policy: Mitomycin for Pyelocalyceal Solution (Jelmyto)

Reference Number: CP.PHAR.495

Effective Date: 09.01.20

Last Review Date: 08.24

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Mitomycin for pyelocalyceal solution (Jelmyto[®]) is an alkylating drug.

FDA Approved Indication(s)

Jelmyto is indicated for the treatment of adult patients with low-grade upper tract urothelial cancer (LG-UTUC).

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Jelmyto is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Low-Grade Upper Tract Urothelial Cancer (must meet all):

1. Newly diagnosed or recurrent LG-UTUC that is both (a and b):
 - a. Above the ureteropelvic junction;
 - b. Non-metastatic;
2. Prescribed by or in consultation with an oncologist or urologist;
3. Age \geq 18 years;
4. Lesion(s) measure \leq 15 mm;
5. For the affected kidney(s), member does not have a recent history (within the last year) of carcinoma in situ in the urinary tract, invasive urothelial carcinoma, or high-grade papillary urothelial carcinoma;
6. Member is not a candidate for or is not seeking nephroureterectomy as definitive treatment;
7. One of the following (a or b):
 - a. Member has had complete or near complete endoscopic resection or ablation;
 - b. Member is not a candidate for endoscopic/surgical intervention;
8. Request meets one of the following (a or b):*
 - a. Dose does not exceed 60 mg once weekly for 6 instillations per kidney;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 3 months (6 instillations per kidney)

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Low-Grade Upper Tract Urothelial Cancer (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Jelmyto for a covered indication and has received this medication for at least 30 days;
2. If member has received 6 instillations, complete response (CR) has been achieved at 3 months after initiation of therapy as evidenced by complete absence of tumor lesions on urine cytology and ureteroscopy;
3. Member has not received more than 17 instillations;
4. If request is for a dose increase, request meets one of the following (a, b, or c):*
 - a. If member has completed < 6 weekly instillations: New dose does not exceed 60 mg once weekly for up to 6 instillations per kidney;
 - b. If member has completed ≥ 6 weekly instillations: New dose does not exceed 60 mg once monthly for up to 11 instillations per kidney;
 - c. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months (up to 17 total instillations per kidney)

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business:

CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

LG-UTUC: low-grade upper tract urothelial cancer

NCCN: National Comprehensive Cancer Network

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): perforation of the bladder or upper urinary tract
- Boxed warning(s): none reported

Appendix D: General Information

- NCCN Compendium currently recommend Jelmyto with a Category 2A recommendation for primary treatment for a non-metastatic, residual, low-grade, low volume (5-15 mm), solitary tumor in the upper urinary tract for a patient who is not a candidate for or not seeking nephroureterectomy as a definitive treatment. Complete or near complete endoscopic resection or ablation is recommended prior to mitomycin ureteral gel application.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
LG-UTUC	<p>Jelmyto is for pyelocalyceal use only and not for intravenous use, topical use, or oral administration.</p> <p>The dose of Jelmyto to be instilled is 4 mg/mL via ureteral catheter or nephrostomy tube, with total instillation volume based on volumetric measurements using pyelography, not to exceed 15 mL (60 mg of mitomycin).</p>	60 mg; 17 instillations

Indication	Dosing Regimen	Maximum Dose
	Instill Jelmyto once weekly for six weeks. For patients with a complete response 3 months after Jelmyto initiation, Jelmyto instillations may be administered once a month for a maximum of 11 additional instillations.	

VI. Product Availability

For pyelocalyceal solution – carton containing the following:

- Two 40 mg (each) single-dose vials of mitomycin for pyelocalyceal solution
- One vial of 20 mL sterile hydrogel for reconstitution

VII. References

1. Jelmyto Prescribing Information. Princeton, NJ: UroGen Pharma, Inc.; September 2022. Available at <https://www.jelmyto.com/>. Accessed May 6, 2024.
2. Kleinmann N, Matin S, Pierorazio P, et al. Primary chemoablation of low-grade upper tract urothelial carcinoma using UGN-101, a mitomycin-containing reverse thermal gel (OLYMPUS): an open-label, single-arm, phase 3 trial. *Lancet Oncol* 2020. Published online April 29, 2020. Available at [https://doi.org/10.1016/S1470-2045\(20\)30147-9](https://doi.org/10.1016/S1470-2045(20)30147-9).
3. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed May 22, 2024.
4. National Comprehensive Cancer Network. Bladder Cancer Version 4.2024. Available at [nccn.org](http://www.nccn.org). Accessed May 22, 2024.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9281	Mitomycin pyelocalyceal instillation, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	05.26.20	08.20
3Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; added HCPCS codes; references reviewed and updated.	03.17.21	08.21
3Q 2022 annual review: updated initial approval criteria to include “member is not candidate for or seeking nephroureterectomy as definitive treatment” to mirror NCCN bladder cancer guidelines, added Appendix D for additional information from NCCN Compendium to support this addition; references reviewed and updated.	04.25.22	08.22

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Template changes applied to other diagnoses/indications.	10.03.22	
3Q 2023 annual review: added criteria that LG-UTUC be non-metastatic; added requirement for endoscopic resection or ablation if member is a candidate per NCCN and New Century Health; references reviewed and updated.	04.13.23	08.23
3Q 2024 annual review: no significant changes; references reviewed and updated.	05.06.24	08.24

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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