CarePartners of Connecticut MEDICARE ADVANTAGE

Medical Necessity Guidelines
Medical Benefit Drugs

Amtagvi (lifileucel)

Effective: January 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers blow.	Yes ☒ No ☐

Applies to:

☒ CarePartners of Connecticut Medicare Advantage HMO plans, Fax 857-304-6463
☒ CarePartners of Connecticut Medicare Advantage PPO plans, Fax 857-304-6463

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Melanoma is one of the most aggressive skin cancers and may spread in an unpredictable manner to involve virtually any organ of the body. Prognosis is informed by pathologic features such as ulceration, thickness, and if it has spread. Most melanomas arise as superficial, indolent tumors that are confined to the epidermis, however those that infiltrate deep into the dermis have the potential to metastasize. Melanoma accounts for only about 1% of skin cancers but causes a large majority of skin cancer deaths. It is the fifth most common cancer in males and females, and its incidence increases with age. About 100,640 new melanomas will be diagnosed in the US in 2024.The median survival of patients with metastatic melanoma is six to nine months after diagnosis.

Melanoma treatment depends on the stage of disease. Patients with locally or regionally confined melanoma may be treated with surgical excision and management of lymph nodes as necessary. For patients with unresectable or metastatic melanoma systemic treatment is required and may include radiation, chemotherapy, and immunotherapy however prognosis is often poor.

Food and Drug Administration (FDA) Approved Indications:

- AMTAGVI is a tumor-derived autologous T cell immunotherapy indicated for the treatment of adult patients 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.

Amtagvi is to be administered in an inpatient hospital setting under the supervision of a physician experienced in the use of anticancer agents. An intensive care facility and specialists skilled in cardiopulmonary or intensive care medicine must be available.

Care Partners of Connecticut uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Medicare Advantage plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals are the basis for coverage determinations where available. When CMS does not provide guidance, Care Partners of Connecticut's internally developed medical necessity guidelines are used. CMS coverage guidelines are not established for this service.

For the therapy Amtagvi, evidence is sufficient for coverage. Amtagvi received FDA approval in February 2024 supported by the results of an ongoing, multicohort, multicenter Phase 2 C-144-01 trial. Effectiveness was established based on objective response rate (ORR) to treatment and duration of response (DOR). Among the primary efficacy analysis set of 73 patients who received Amtagvi at the recommended dose, the ORR was 31.5% and the median DOR was not reached at 18.6 months follow-up. Among a pooled efficacy set of 153 patients from Cohorts 2 and 4 who received the recommended Amtagvi dose, the ORR was 31.4% and the median DOR was not reached at 21.5 months follow-up. The manufacturer is conducting a phase 3 trial (TILVANCE-301) to confirm the drug's clinical benefit.

The use of this criteria in the utilization management process will ensure access to evidence based clinically appropriate care. See References section below for all evidence accessed in the development of these criteria.

Clinical Guideline Coverage Criteria

The Plan considers Amtagvi as reasonable and medically necessary when **all** the following clinical criteria is met:

1. The Member has a documented diagnosis of unresectable or metastatic melanoma; **AND**
2. The Member is ≥ 18 years of age; **AND**
3. The Prescriber is an oncologist; **AND**
4. The Member has had an inadequate response or adverse reaction to ONE or a contraindication to ALL appropriate PD-1 blocking antibodies; **AND**
5. If BRAF V600 mutation-positive, the Member has had an inadequate response or adverse reaction to ONE or contraindication to ALL BRAF inhibitors; **AND**
6. Infusion will take place in a qualified treatment center

Limitations

- Any indications for Amtagvi other than those outlined above are considered investigational and will not be covered.
- Authorization of Amtagvi is limited to one single dose treatment.
- Amtagvi therapy is contraindicated in pregnancy.

Codes

The following codes are associated with this service:

Table 1: HCPCS Codes

Code	Description
	None

References:

1. Chesney J, Lewis KD, Kluger H, et al. Efficacy and safety of lifileucel, a one-time autologous tumor-infiltrating lymphocyte (TIL) cell therapy, in patients with advanced melanoma after progression on immune checkpoint inhibitors and targeted therapies: pooled analysis of consecutive cohorts of the C-144-01 study. J Immunother Cancer. 2022;10(12):e005755. doi:10.1136/jitc-2022-005755.
2. New Drug Review: Amtagvi (lifileucel). IPD Analytics. February 2024
3. Hayes, Inc. Emerging Technology Report. Lifileucel (Amtagvi; Iovance Biotherapeutics Inc.) for Advanced Melanoma. February 27, 2024. Available at hayesinc.com [subscription required]. Last accessed September 23, 2025.
4. Amtagvi (lifileucel). [package insert]. Philadelphia, PA: Iovance Biotherapeutics; Feb 2024.
5. Study of Lifileucel (LN-144), Autologous Tumor Infiltrating Lymphocytes, in the Treatment of Patients With Metastatic Melanoma (LN-144); NCT02360579. Accessed @ https://clinicaltrials.gov/study/NCT02360579 accessed March 7, 2024
6. Study to Investigate Lifileucel Regimen Plus Pembrolizumab Compared With Pembrolizumab Alone in Participants With Untreated Advanced Melanoma; NCT05727904. Accessed @ https://clinicaltrials.gov/study/NCT05727904 accessed March 7, 2024
7. Edge SB BD, Compton CC, Fritz AG. AJCC cancer staging manual. New York: Springer, 2010.
8. What Are The Stages of Melanoma? AIM at Melanoma Foundation. https://www.aimatmelanoma.org/stages-of-melanoma/. Accessed April 3, 2024.
9. ECOG Performance Status Scale. ECOG-ACRIN Cancer Research Group. ECOG Performance Status Scale - ECOG-ACRIN Cancer Research Group. Accessed April 4, 2024.
10. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. Melanoma: Cutaneous. (Version 2.2025). January 28, 2025. Accessed September 18, 2025. https://www.nccn.org/professionals/physician_gls/pdf/cutaneous_melanoma.pdf
11. Addendum 1: Society for Immunotherapy of Cancer (SITC) clinical practice guideline on immunotherapy for the treatment of melanoma, version 3.0. J Immunother Cancer. 2025 Mar 17;13(3):e006947add1. doi: 10.1136/jitc-2023-006947add1. Erratum for: doi: 10.1136/jitc-2023-006947. PMID: 40101802; PMCID: PMC12308135.
12. Garbe C, et. al. European Association of Dermato-Oncology (EADO), the European Dermatology Forum (EDF), and the European Organization for Research and Treatment of Cancer (EORTC). European consensus-based interdisciplinary guideline for melanoma. Part 2: Treatment - Update 2024. Eur J Cancer. 2025 Jan 17;215:115153. doi: 10.1016/j.ejca.2024.115153. Epub 2024 Nov 29. PMID: 39709737.

Approval And Revision History

May 15, 2024: Reviewed by the Medical Policy Approval Committee (MPAC)

Subsequent endorsement date(s) and changes made:

- May 15, 2024: Reviewed by MPAC effective July 1, 2024
- June 13, 2024: Reviewed and approved by UM Committee effective July 1, 2024
- June 20, 2024: Reviewed by MPAC. Criteria update to align with MassHealth criteria effective September 1, 2024
- November 21, 2024: Reviewed by MPAC, renewed without changes, effective January 1, 2025
- December 13, 2024: Reviewed and approved by the UM Committee, effective January 1, 2025
- November 19, 2025: Reviewed by MPAC for annual review, renewed without changes, references updated, effective January 1, 2026
- December 8, 2025: Reviewed by UM Committee for annual review, renewed without changes effective January 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.