

DRUG POLICY

Emrelis® (telisotuzumab vedotin-tllv)

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

The intent of the policy is to provide coverage consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines. The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Emrelis is indicated for the treatment of adult patients with locally advanced or metastatic, non-squamous non-small cell lung cancer (NSCLC) with high c-Met protein overexpression [greater than or equal to 50% of tumor cells with strong (3+) staining], as determined by an FDA-approved test, who have received a prior systemic therapy.

POLICY

Required Documentation

Submission of the following information is necessary to initiate the prior authorization review: c-Met protein expression status.

Criteria for Initial Approval

Non-Small Cell Lung Cancer (NSCLC)

1. Authorization of **12 months** may be granted for treatment of locally advanced or metastatic non-squamous NSCLC with high c-Met protein overexpression [greater than or equal to 50% of tumor cells with strong (3+) staining], for members who have received a prior systemic therapy.

Continuation of Therapy

Non-Small Cell Lung Cancer (NSCLC)

1. Authorization of **12 months** may be granted for continued treatment in members requesting reauthorization for an indication listed in the Criteria for Initial Approval section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

Other

Emrelis (telisotuzumab vedotin-tllv) is considered **not medically necessary** for members who do not meet the criteria set forth above.

Dosing and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Quantity Limits Apply

Medication	Standard Limit	FDA Recommended Dosing
Emrelis (telisotuzumab vedotin-tllv) 20 mg/vial IV infusion	8 vials per 28 days	1.9 mg/kg administered as an intravenous infusion over 30 minutes every 2 weeks until disease progression or unacceptable toxicity. <ul style="list-style-type: none"> • Up to a maximum of 190 mg for patients greater than or equal to 100 kg
Emrelis (telisotuzumab vedotin-tllv) 100 mg/vial IV infusion	4 vials per 28 days	

PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

- J9326 – Injection, telisotuzumab vedotin-tllv, 1 mg (effective 1/1/26)
- C9306 - Injection, telisotuzumab vedotin-tllv, 1 mg (cancelled 12/31/25)

REFERENCES

1. Emrelis [package insert]. North Chicago, IL: AbbVie Inc.; May 2025.

POLICY HISTORY

Policy #: 05.06.02

Original Effective Date: 10/16/2025

Reviewed: August 2025

Revised:

Current Effective Date: 10/16/2025