DRUG POLICY

Tudriqev® (vusolimogene oderparepvec-wtpg)

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
Tudriqev is indicated in combination with nivolumab for the treatment of adult patients with unresectable advanced cutaneous melanoma who experienced disease progression with a programmed death receptor-1 (PD-1)-blocking antibody-based regimen.

POLICY

Required Documentation
Submission of the following information is necessary to initiate the prior authorization review: chart notes or medical record documentation confirming unresectable advanced cutaneous melanoma, disease progression with a PD-1-blocking antibody-based regimen, and planned use of Tudriqev in combination with nivolumab.

Prescriber Specialties
The requested medication must be prescribed by or in consultation with one of the following: Oncologist

Criteria for Initial Approval
Cutaneous Melanoma
Authorization of 12 months may be granted for the treatment of unresectable advanced cutaneous melanoma when the member has experienced disease progression with a programmed death receptor-1

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(PD-1)-blocking antibody-based regimen and the requested medication will be used in combination with nivolumab.

Continuation of Therapy

Cutaneous Melanoma

Authorization of 12 months (including new members) may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when there is no evidence of disease progression or unacceptable toxicity while on the current regimen.

Other

Tudriqev (vusolimogene oderparepvec-wtpg) 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
Tudriqev (vusolimogene oderparapvec-wtpg)	Maximum of 10 mL per treatment course, administered every 2 weeks	1 mL per centimeter of the largest dimension of the tumor for maximum of 10 mL across all lesions treated with each dose

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.

- C9399 – unclassified biologic
- J9999 – Chemotherapy drug

REFERENCES

- Tudriqev [package insert]. Framingham, MA: Replimune, Inc.; August 2026.

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