Harvard Pilgrim Health Care | TUFTS Health Plan

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.	Yes ☒ No ☐

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax 617-673-0988
☒ Tufts Health Plan Commercial products; Fax 617-673-0988

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 617-673-0988
☐ Tufts Health Together – MassHealth Accountable Care Partnership Plans; Fax 617-673-0939
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 617-673-0939
☐ Tufts Health One Care-- A dual-eligible product; Fax 617-673-0956

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0956
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0956
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0956

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.

Clinical Guideline Coverage Criteria

The Plan may cover Amtagvi for members aged 18 years or older when **all** the following clinical criteria is met:

1. The Member has a documented diagnosis of unresectable or metastatic melanoma (stage IIIC or stage IV); **AND**
2. The Member's disease has progressed and prior treatment has included ≥ 1 systemic therapy including a PD-1 blocking antibody, and if BRAF V600 mutation-positive, a BRAF inhibitor, BRAF inhibitor plus a MEK inhibitor; **AND**
3. The Member has at least one resectable lesion (or aggregate of lesions resected) of ≥1.5cm in diameter post-resection

4. The Member has an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 1; **AND**
5. The Member has an estimated life expectancy of ≥ 3 months; **AND**
6. The Member does NOT have any of the following:
    a. Uncontrolled brain metastases
    b. Organ allograft of prior cell transfer
    c. Melanoma of uveal or ocular origin
    d. Systemic steroid therapy for any reason
    e. Grade 2 or higher hemorrhage within 14 days prior to study enrollment (tumor resection)
    f. Active systemic infections (e.g., viral, bacterial, fungal) including HIV, active hepatitis B or active hepatitis C. The Provider attests/documents that active systemic infections (viral, bacterial, fungal) has been excluded at the time of tissue harvesting and are not present at the time infusion.
    g. Abnormal cardiac function characterized by left ventricular ejection fraction ≤45% or New York Heart Association (NYHA) functional classification greater than Class 1
    h. Abnormal lung function characterized by forced expiratory volume in one second (FEV1) ≤60%; **AND**
7. Infusion will take place in an authorized treatment center (ATC)

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

ECOG Performance Status

0: Fully active, no restrictions on activities. A performance status of 0 means no restrictions in the sense that someone is able to do everything they were able to do prior to their diagnosis.

1: Unable to do strenuous activities, but able to carry out light housework and sedentary activities. This status basically means you can't do heavy work but can do anything else. 5 Modified T-Cell Therapies

2: Able to walk and manage self-care, but unable to work. Out of bed more than 50% of waking hours. In this category, people are usually unable to carry on any work activities, including light office work.

3: Confined to bed or a chair more than 50 percent of waking hours. Capable of limited selfcare.

4: Completely disabled. Totally confined to a bed or chair. Unable to do any self-care.

5: Death

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	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 March 7, 2024.
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), effective July 1, 2024

Subsequent endorsement date(s) and changes made:
- November 21, 2024: Reviewed by MPAC, renewed without changes, effective January 1, 2025
- May 21, 2025: Reviewed by MPAC, removed screening requirement and added provider attestation language. Effective July 1, 2025.
- June 18, 2025: Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template
- November 19, 2025: Reviewed by MPAC for annual review, renewed without changes, references updated, effective January 1, 2026
- December 2025: Administrative updates 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.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

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.