

Clinical Policy: Trabectedin (Yondelis)

Reference Number: CP.PHAR.204

Effective Date: 05.01.16

Last Review Date: 02.26

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

Trabectedin (Yondelis[®]) is an alkylating drug.

FDA Approved Indication(s)

Yondelis is indicated for the treatment of patients with unresectable or metastatic liposarcoma (LPS) or leiomyosarcoma (LMS) who received a prior anthracycline-containing regimen.

Policy/Criteria

Provider must submit documentation (including 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 Yondelis is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Soft Tissue Sarcoma** (must meet all):

1. Diagnosis of one of the following soft tissue sarcomas (STS) (a, b, or c) (*see Appendix D for examples*):
 - a. STS that is unresectable, progressive, or advanced/metastatic;
 - b. Myxoid liposarcoma (LPS) that is one of the following (i, ii, iii, iv, or v):
 - i. Resectable;
 - ii. High risk for metastatic disease;
 - iii. Local recurrence;
 - iv. Unresectable primary disease;
 - v. Stage IV disease that is amendable to local therapy;
 - c. Solitary fibrous tumor, epithelioid hemangioendothelioma, or dedifferentiated liposarcoma with or without concurrent well-differentiated liposarcoma;
2. Prescribed by or in consultation with an oncologist;
3. Age \geq 18 years;
4. If uterine leiomyosarcoma (uLMS), prescribed in one of the following ways (a or b):
 - a. As a single agent AND member has received a prior anthracycline-containing regimen (e.g., doxorubicin);
 - b. In combination with doxorubicin;
5. Request meets one of the following (a or b):*
 - a. Dose does not exceed 1.5 mg/m² body surface area every 3 weeks;
 - 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:

Medicaid/HIM – 12 months

Commercial – 6 months or to the member's renewal date, whichever is longer

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.190 for commercial, HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Soft Tissue Sarcoma (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Yondelis for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):*
 - a. New dose does not exceed 1.5 mg/m² body surface area every 3 weeks;
 - b. 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:

Medicaid/HIM – 12 months

Commercial – 6 months or to the member's renewal date, whichever is longer

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.190 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 policy – CP.CPA.190 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

LMS: leiomyosarcoma

LPS: liposarcoma

STS: soft tissue sarcoma

uLMS: uterine leiomyosarcoma

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
uLMS - examples of anthracycline-containing regimens: doxorubicin ± gemcitabine, olaratumab, fosfamide, or dacarbazine; epirubicin; liposomal doxorubicin	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): known hypersensitivity to trabectedin
- Boxed warning(s): none reported

Appendix D: Types and Examples of STSs

Examples are drawn from the National Comprehensive Center Network (NCCN) Soft Tissue Sarcoma Guideline, which cites the 2020 World Health Organization classification of tumors, and the Yondelis compendium.

- Smooth muscle tumors - LMS

- Vascular tumors - angiosarcoma
- Myo/fibroblastic tumors - solitary fibrous tumor
- Skeletal muscle tumors - rhabdomyosarcoma
- Adipocytic tumors – myxoid LPS
 - Begin in the adipose cells, usually occurring in the thigh and sometimes in the outer torso or buttocks
 - Myxoid LPS has a higher risk of metastasis to the spine compared to other STSs

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
LPS, LMS	1.5 mg/m ² (body surface area) as a 24-hour IV infusion every 21 days (3 weeks), until disease progression or unacceptable toxicity	Varies

VI. Product Availability

Single-dose vial with powder for injection: 1 mg

VII. References

1. Yondelis Prescribing Information. Horsham, PA: Janssen Products, LP; June 2020. Available at: <http://www.yondelis.com>. Accessed: November 6, 2025.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: www.nccn.org. Accessed November 19, 2025.
3. National Comprehensive Cancer Network. Soft Tissue Sarcoma Version 1.2025. Available at: www.nccn.org. Accessed November 19, 2025.
4. National Comprehensive Cancer Network. Uterine Neoplasms Version 2.2026. Available at: www.nccn.org. Accessed November 19, 2025.

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.

HCPSC Codes	Description
J9352	Injection, trabectedin, 0.1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 annual review: added myxoid LPS indication supported as category 2A in NCCN compendium; added Appendix D with STS examples; references reviewed and updated.	11.09.21	02.22
Template changes applied to other diagnoses/indications.	10.03.22	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2023 annual review: no significant changes; references reviewed and updated.	11.03.22	02.23
1Q 2024 annual review: for uLMS, clarified Yondelis prescribed as single agent for those who has received a prior anthracycline-containing regimen and added option for usage of Yondelis in combination with doxorubicin; references reviewed and updated.	10.16.23	02.24
1Q 2025 annual review: added Commercial line of business; for myxoid LPS, added option for unresectable primary disease and Stage IV disease that is amendable to local therapy; references reviewed and updated.	10.21.24	02.25
1Q 2026 annual review: added the following sub-types of STS without requiring disease to be unresectable or metastatic: solitary fibrous tumor, epithelioid hemangioendothelioma, or dedifferentiated liposarcoma with or without concurrent well-differentiated liposarcoma per NCCN; for Medicaid/HIM extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.	11.06.25	02.26

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.

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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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