Clinical Policy: Valrubicin (Valstar)

Reference Number: CP.PHAR.439
Effective Date: 09.04.18
Last Review Date: 11.25
Line of Business: Commercial, Medicaid, HIM

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Valrubicin (Valstar®) is an anthracycline topoisomerase inhibitor.

FDA Approved Indication(s)

Valstar is indicated for the intravesical therapy of bacillus Calmette-Guerin (BCG)-refractory carcinoma *in situ* (CIS) of the urinary bladder in patients for whom immediate cystectomy would be associated with unacceptable morbidity or mortality.

Policy/Criteria

Provider must submit documentation (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 Valstar and valrubicin are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Bladder Cancer (must meet all)**:**

1. Diagnosis of CIS of the urinary bladder;
2. Prescribed by or in consultation with an oncologist or urologist;
3. Age ≥ 18 years;
4. One of the following (a or b)*:
   a. Member is refractory to BCG* treatment and is not a candidate for cystectomy;
      **Prior authorization may be required for BCG immunotherapy*
   b. Prescribed as initial or adjuvant intravesical chemotherapy for non-muscle invasive bladder cancer (NMIBC) in the event of a BCG shortage (*see Appendix D for information on BCG shortage*);
5. For brand Valstar requests, member must use generic valrubicin, unless contraindicated or clinically significant adverse effects are experienced
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 800 mg per week for a total of 6 doses;
   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: 6 weeks (6 doses)

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

II. Continued Therapy

A. Bladder Cancer (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Valstar or valrubicin for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. Member has not yet received a total of 6 doses;
4. For brand Valstar requests, member must use generic valrubicin, unless contraindicated or clinically significant adverse effects are experienced;
5. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 800 mg per week up to a total of 6 doses;
   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: Up to a total of 6 weeks (up to a total of 6 doses)

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.09 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 policies – CP.CPA.09 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

AUA: American Urological Association
BCG: bacillus Calmette-Guerin
CIS: carcinoma *in situ*
FDA: Food and Drug Administration
NMIBC: non-muscle-invasive bladder cancer

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
Bacillus Calmette-Guerin live (TICE BCG®)	1 to 8 × 10^8 CFU (a vial) intravesical instillation once per week for 6 weeks	1 to 8 × 10^8 CFU/week

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):
  - Perforated bladder or compromised bladder mucosa
  - Known hypersensitivity to anthracyclines or polyoxyl castor oil
  - Concurrent urinary tract infections
  - Small bladder capacity, i.e., unable to tolerate a 75 mL instillation
- Boxed warning(s): none reported

Appendix D: General Information

- Carcinoma *in situ* (Tis in TNM staging system) refers to early cancer that has not spread to neighboring tissue.
- Centers for Disease Control's current shortages page: https://www.fda.gov/vaccines-blood-biologics/safetyavailability-biologics/cber-regulated-products-current-shortages
- National Comprehensive Cancer Network (NCCN) and American Urological Association (AUA) information and recommendations:
  - Standard urinary bladder CIS therapy includes lesion resection followed by intravesical BCG.

- The NCCN and AUA advise that in the event of a BCG shortage, BCG should be prioritized for induction of high-risk patients (e.g., high-grade T1 and CIS) and that, if feasible, the dose of BCG may be split (1/3 or 1/2 dose) so that multiple patients may be treated with a single vial in the event of a shortage.
- If BCG is unavailable, the NCCN and AUA recommend the following alternatives:
  - Intravesical chemotherapy agents as first-line and subsequent therapy (e.g., gemcitabine, mitomycin, epirubicin, valrubicin, docetaxel, sequential gemcitabine/docetaxel, gemcitabine/mitomycin);
  - Initial radical cystectomy if patient is a surgical candidate.

1. National Comprehensive Cancer Network Guidelines. Bladder Cancer Version 1.2025. Available at https://www.nccn.org/professionals/physician_gls/pdf/bladder.pdf. Accessed July 22, 2025.
2. American Urological Association. BCG Shortage Info. Feb 2019. Available at: https://www.auanet.org/about-us/bcg-shortage-info. Accessed July 22, 2025.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Bladder CIS	800 mg intravesically once every week for 6 weeks	800 mg/dose

VI. Product Availability

Single-use vial: 200 mg/5 mL

VII. References

1. Valrubicin Prescribing Information. Berkeley Heights, NJ: Hikma Pharmaceuticals USA Inc.; June 2022. Available at: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=8739ae02-e4c5-0fa2-e053-2a91aa0a1b74. Accessed July 22, 2025.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed July 22, 2025.
3. Quan Y, Jeong CW, Kwak C, et al. Dose, duration, and strain of bacillus Calmette-Guerin in the treatment of nonmuscle invasive bladder cancer. Medicine (Baltimore). 2017; 96(2):e8300.
4. National Comprehensive Cancer Network. Bladder Cancer Version 1.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/bladder.pdf. Accessed July 22, 2025.
5. American Urological Association: Important message about the BCG shortage: Important message about the BCG shortage. Accessed July 22, 2025.
6. Holzbeierlein J, Bixler BR, Buckley DI, et al. Diagnosis and treatment of non-muscle invasive bladder cancer: AUA/SUO guideline: 2024 amendment. *J Urol.* 2024;10.1097/JU.0000000000003846.

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.

HCPCS Codes	Description
J9357	Injection, valrubicin, intravesical, 200 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2021 annual review: clarified in initial approval that request not exceed a total of 6 doses in accordance with authorization duration; references for HIM line of business off-label use revised from HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	08.09.21	11.21
4Q 2022 annual review: no significant changes; references reviewed and updated. Template changes applied to other diagnoses/indications.	08.16.22	11.22
4Q 2023 annual review: Commercial line of business added; references reviewed and updated.	06.30.23	11.23
4Q 2024 annual review: clarified that policy applies to generic valrubicin; added criterion for brand Valstar requests, that member must use generic valrubicin; references reviewed and updated.	08.07.24	11.24
4Q 2025 annual review: added option of urologist to fulfill specialist requirement; removed specification of recurrent or persistent disease and added option for use as initial intravesical chemotherapy for NMIBC per NCCN; clarified failure of BCG to member is refractory to BCG treatment and added criterion that member is not a candidate for cystectomy per FDA labeling; references reviewed and updated.	07.22.25	11.25

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.