Clinical Policy: Imlunestrant (Inluriyo)

Reference Number: CP.PHAR.754
Effective Date: 12.01.25
Last Review Date: 11.25
Line of Business: Commercial, HIM, Medicaid Revision Log

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

Description

Imlunestrant (Inluriyo™) is an estrogen receptor antagonist.

FDA Approved Indication(s)

Inluriyo is indicated for treatment of adults with estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative, estrogen receptor-1 (ESR1)-mutated advanced or metastatic breast cancer with disease progression following at least one line of endocrine therapy.

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 Inluriyo is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of breast cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease has all of the following characteristics (a, b, c, and d):
   a. ER-positive;
   b. HER2-negative;
   c. ESR1-mutated;
   d. Advanced (including locally advanced) or metastatic;
5. Disease has progressed following at least one line of endocrine therapy (*see Appendix B for examples*);
6. If member is a premenopausal or perimenopausal biological female, member has been treated with ovarian ablation or is receiving ovarian suppression (*see Appendix D*);
7. If member is a biological male, member is receiving an agent that suppresses testicular steroidogenesis (e.g., gonadotropin-releasing hormone agonists);
8. For brand Inluriyo requests, member must use generic imlunestrant, if available, unless contraindicated or clinically significant adverse effects are experienced;
9. Request meets one of the following (a or b):*
   a. Dose does not exceed one of the following (i or ii):
      i. 400 mg (2 tablets) per day;

ii. If member is receiving a concomitant strong CYP3A inducer (e.g., carbamazepine, fosphenytoin, phenytoin, rifampin): 600 mg (3 tablets) per day;

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: 12 months

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. Breast Cancer (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Inluriyo for breast cancer and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. Dose is ≥ 200 mg per day;
4. For brand Inluriyo requests, member must use generic imlunestrant, if available, 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 one of the following (i or ii):
      i. 400 mg (2 tablets) per day;
      ii. If member is receiving a concomitant strong CYP3A inducer (e.g., carbamazepine, fosphenytoin, phenytoin, rifampin): 600 mg (3 tablets) per day;
   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: 12 months

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

ER: estrogen receptor
ESR1: estrogen receptor-1
FDA: Food and Drug Administration
HER2: human epidermal growth factor receptor 2
HR: hormone receptor
LHRH: luteinizing hormone-releasing hormone
NCCN: National Comprehensive Cancer Network

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
Endocrine Therapy		
anastrozole (Arimidex®)	1 mg PO QD	1 mg/day
exemestane (Aromasin®)	25 mg PO QD	25 mg/day
fulvestrant (Faslodex®)	500 mg IM as two 5 mL injections, one in each buttock, on days 1, 15, 29 and once monthly thereafter	See regimen
letrozole (Femara®)	2.5 mg PO QD	2.5 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
megestrol acetate	40 mg PO QID	160 mg/day
tamoxifen (Nolvadex®, Soltamox®)	20 to 40 mg PO QD	40 mg/day
toremifene (Fareston®)	60 mg PO QD	60 mg/day

Drug names 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
None reported

Appendix D: General Information
- National Comprehensive Cancer Network (NCCN):
  - Ovarian ablation may be accomplished by surgical oophorectomy or by ovarian irradiation. Ovarian suppression utilizes luteinizing hormone-releasing hormone (LHRH) agonists that result in suppression of luteinizing hormone and release of follicle-stimulating hormone from pituitary and reduction in ovarian estrogen production. Examples of LHRH agonists include, but are not limited to, goserelin and leuprolide.
  - The NCCN recommends that men with breast cancer be treated similarly to postmenopausal women; however, it is preferred that when an aromatase inhibitor is used, a LHRH analog should be given concurrently.
- In Inluriyo's pivotal study for approval (EMBER-3; NCT04975308), all premenopausal women, perimenopausal women, and men received a gonadotropin-releasing hormone agonist.

V. Dosage and Administration

Indication	Dosing Regimen*	Maximum Dose
Breast cancer	400 mg PO QD If receiving a concomitant strong CYP3A inducer: 600 mg PO QD Pre/perimenopausal women and men should receive a gonadotropin-releasing hormone agonist according to current clinical practice standards	600 mg/day

**If a dose reduction to < 200 mg/day is required, therapy should be discontinued.*

VI. Product Availability
Tablet: 200 mg

VII. References
1. Inluriyo Prescribing Information. Indianapolis, IN; Lilly USA, LLC; September 2025. Available at: https://www.inluriyo.com. Accessed September 30, 2025.
2. National Comprehensive Cancer Network. Breast Cancer Version 4.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed September 30, 2025.

3. Jhaveri KL, Neven P, Casalnuovo ML, et al. Imlunestrant with or without abemaciclib in advanced breast cancer. N Engl J Med. 2025; 392(12): 1189-1202.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	09.30.25	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.