PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

PHC Medi-Cal
Effective: July 1st, 2024

P & T: April 4th, 2024

Approved New & Revised PA Criteria:

Brand/Trade names are shown for reference purposes only. Criteria apply to the generic product when a generic equivalent has been approved by the FDA. Additional criteria apply to brand name requests (when a generic is available), per PHC Policy #MPRP4033.

1. Requirements for Reslizumab IV infusion (Cinqair™)
2. Requirements for Benralizumab (Fasenra™ Autoinjector Pen & Fasenra™ Prefilled Syringe)
3. Requirements for Omalizumab (Xolair™ Prefilled Syringe & Xolair™ Vial)
4. Standard Requirements for Antibiotic Injections
5. Requirments for Lovotibeglogene Autotemcel (Lyfgenia™)
6. Requirements for Exagamglogene Autotemcel (Casgevy™)
7. Requirements for Chimeric Antigen Receptor T-cell (CAR-T) Therapy

Requirements for Reslizumab IV infusion (Cinqair™)

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	Add-on maintenance treatment of severe asthma in adults with an eosinophilic phenotype
Exclusion Criteria	• Monotherapy use (reslizumab is add on therapy to the current asthma treatment regimen) • Reslizumab will not be used concurrently with other monoclonal antibodies with similar indications such as dupilumab, mepolizumab, omalizumab, benralizumab or tezepelumab
Required Medical Information	Clinic notes must include all of the following: 1) Patient has a diagnosis of severe asthma with eosinophilic phenotype and has a blood eosinophil count equal to or greater than 400 cells/µl. 2) Patient has persistent uncontrolled asthma despite at least 3 months of compliant use of high-dose inhaled corticosteroid (ICS) combined with long-acting β2 agonist (LABA) (ICS-LABA) as defined by at least one of the following: a. An Asthma Control Questionnaire (ACQ) score of 1.5 or more, or an Asthma Control Test (ACT) score less than 20 at baseline. b. At least two exacerbations in the past 12 months. c. A history of Emergency Department (ED) visits requiring use of oral/systemic corticosteroids and/or hospitalization in the past 12 months. d. Reduced lung function at baseline [pre-bronchodilator FEV1 below 80% in adults, and below 90% in adolescents]. 3) Documentation of trial and failure/or contraindication to less invasive treatment option with biologics given subcutaneously which are indicated to treat severe asthma in adults with an eosinophilic phenotype (ie., dupilumab, mepolizumab, benralizumab). 4) Current patient weight for dose calculation.
Age Restriction	18 years and older
Prescriber Restriction	Must be prescribed or recommended by an allergist or pulmonologist.
Coverage Duration	Initial approval: 6 months Renewal: 12 months with documentation of clinical benefit with treatment when compared to baseline (see further details in "Other Criteria" section below).
Other Requirements & Information	Renewal criteria: 1) Current FEV1, peak flow and/or other pulmonary function test that may indicate improvement in airflow limitations 2) Asthma Control Questionnaire (ACQ) or Asthma Control Test (ACT) after a minimum of 3 months after initiation of treatment with reslizumab to indicate improvement from baseline score. *Note: Pharmacy claim history will be reviewed for renewal requests, and rescue inhalers should not show increasing use. If the fill history does show an increase for use for rescue inhalers, then additional justification of Reslizumab efficacy may be requested.* Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Requirements for Reslizumab IV infusion (Cinqair™)

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J2786	Injection, reslizumab, per 1 mg (Cinqair™)	3 mg/kg IV q4 weeks

Requirements for Benralizumab (Fasenra™ AutoInjector Pen & Fasenra™ Prefilled Syringe)

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment.

PA Criteria	Criteria Details
Covered Uses	Add-on maintenance treatment of severe asthma in adults with an eosinophilic phenotype.
Exclusion Criteria	• Monotherapy use (benralizumab is add on therapy to the current asthma treatment regimen) • Benralizumab will not be used concurrently with other monoclonal antibodies with similar indications such as dupilumab, mepolizumab, omalizumab, reslizumab or tezepelumab
Required Medical Information	Must submit clinical documentation to substantiate the following: 1) Must be used for FDA approved indications and dosages 2) Patient has a diagnosis of severe asthma with an eosinophilic phenotype and has a blood eosinophil counts equal to or greater than 150 cells/μL 3) Patient has persistent uncontrolled asthma despite at least 3 months of compliant use of high-dose inhaled corticosteroid (ICS) combined with long-acting β2 agonist (LABA) (ICS-LABA) as defined by at least one of the following: a. An Asthma Control Questionnaire (ACQ) score of 1.5 or more, or an Asthma Control Test (ACT) score less than 20 at baseline b. At least two exacerbations in the previous year. c. A history of Emergency Department (ED) visits requiring use of oral/systemic corticosteroids and/or hospitalization in the past year 4) Reduced lung function at baseline [pre-bronchodilator FEV1 below 80% in adults, and below 90% in adolescents] State the specific dosage form that will be administered during the medical office visit: a. Fasenra™ Autoinjector pen (may be administered by patient or caregiver with proper training) OR b. Fasenra™ Prefilled syringe (administered by health care provider)
Age Restriction	Must be 12 years of age or older.
Prescriber Restriction	None
Coverage Duration	Prefilled syringes: 3 doses (3 months) to allow administration of loading doses and for self-administration training with the goal of transitioning to the autoinjector pen for maintenance treatment at home (provided by the pharmacy). Autoinjector pens: 1 time dose for training & observation of self-administration technique.

Requirements for Benralizumab (Fasenra™ AutoInjector Pen & Fasenra™ Prefilled Syringe)

Other Requirements & Information	Benralizumab (Fasenra™) is available for self-administration in the form of an auto-injector and is typically administered by the member or a caregiver at home. As soon as the maintenance dose is established and member or caregiver can be trained for self-administration, Fasenra™ autoinjector should be provided to the member by a pharmacy for administration at home whenever possible. Prefilled syringes: Requests will be approved for up to 3 months, if the healthcare provider prefers to administer the loading dose for new start requests, by obtaining it though the practice until maintenance dose and safety of self-administration is determined. Autoinjector pens: Requests will be approved for one-time to allow training of the member &/or caregiver on self-administration. Continuing to provide pens through the medical office will require information submitted with the TAR documenting the member is not a candidate for self- or caregiver administration at home. If administration by the provider is requested beyond the time frames shown above, the provider must include reason(s) on the renewal TAR stating why the member or caregiver cannot obtain the drug through the pharmacy benefit for self- or caregiver administration.

Medical Billing:

Dose limits & billing requirements (approved TAR is required):

HCPCS	Description	Dosing, Units
J0517	Injection, benralizumab, per 1 mg (Fasenra™ auto-injector pen & Fasenra™ prefilled syringe)	30 mg subcutaneously every 4 weeks x 3 doses, and then once every 8 weeks thereafter. Maximum Dose: 30 mg (30 HCPCS units)

Requirements for Omalizumab (Xolair™ Prefilled Syringe & Xolair™ Vial)

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment.

PA Criteria	Criteria Details
Covered Uses	1) Moderate-to-severe persistent asthma in patients who have a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids 2) Chronic idiopathic urticaria (CIU) in patients 12 years of age and older who remain symptomatic despite H1 antihistamine treatment. 3) Nasal Polyps 4) IgE-mediated food allergy
Exclusion Criteria	• Asthma treatment other than for moderate-severe persistent asthma with positive test for perennial aeroallergen. • Treatment of acute urticaria (hives that last less than 6 weeks). • Omalizumab will not be used concurrently with other monoclonal antibodies with similar indications such as benralizumab, dupilumab, mepolizumab, reslizumab or tezepelumab • The treatment of other allergic conditions or other forms of urticaria. • The relief of acute bronchospasm or status asthmaticus
Required Medical Information	TARs must include clinical documentation that demonstrates all of the following: <u>Asthma</u>: 1) The service is medically necessary to treat moderate-to-severe persistent asthma. Severe asthma as defined by symptoms that are persistent and uncontrolled despite: a. The use of high dose inhaled corticosteroids combined with a long-acting beta2 agonist, leukotriene receptor agonist, or theophylline for the previous one year or longer OR b. The use of systemic glucocorticoids for 50% or more of the previous year. 2) Persistent uncontrolled asthma as defined by at least one of the following: a. An ACQ score consistently greater than 1.5 (Asthma Control Questionnaire) OR ACT score less than 20 (Asthma Control Test). b. Two or more exacerbations in the previous year, each requiring 3 or more days of treatment with systemic glucocorticoids. c. A history of hospitalization, intensive care unit stay, or mechanical ventilation in the previous year. d. A FEV1 (Forced Expiratory Volume in 1 second) at less than 80% of predicted after bronchodilator administration measured by pulmonary function testing or spirometry and documented by report and interpretation. 3) A positive skin test or in vitro reactivity to a perennial aeroallergen. 4) Symptoms are inadequately controlled with inhaled corticosteroids. 5) Pre-treatment serum IgE level between 30 and 700 IU/ml. <u>Chronic Idiopathic Urticaria (CIU)</u>: 1) The service is medically necessary to treat CIU for patients 12 years of age and older who remain symptomatic despite H1 antihistamine treatment. <u>Nasal polyps</u>: 1) Documentation of chronic rhinosinusitis with nasal polyposis with: a. Pretreatment serum IgE level is required for new starts, or prior to restart of treatment when there has been a break of 1 year or more. b. Current member weight.

Requirements for Omalizumab (Xolair™ Prefilled Syringe & Xolair™ Vial)

	c. Minimum of least 2 failed prior trials of short course oral corticosteroid (7-21 days), followed by: i. A treatment course of nasal corticosteroid use at doses for the treatment of nasal polyps for a minimum of 3 months, AND ii. Adjunctive therapy with a leukotriene antagonist. 2) Documentation of trial and reason(s) for failure with dupilumab (Dupixent™). IgE-mediated food allergy: 1) Diagnosis of IgE-mediated food allergy to one or more foods documented in clinical history. 2) Positive skin prick test and/or serum IgE test confirming food allergies. 3) Dose is consistent with FDA approved dose according to pretreatment total serum IgE levels and body weight. 4) Xolair™ is being requested to use in conjunction with a diet that avoids food allergen(s). 5) Xolair™ is not used concomitantly with Palforzia™. For all indication above: 1) State the specific dosage form that will be administered during the medical office visit: a. Xolair™ Prefilled Syringes (may be administered by patient or caregiver with proper training) OR b. Xolair™ Vials (administered by health care provider)
Age Restriction	Asthma: 6 years and older. Chronic Urticaria: 12 years and older. Nasal Polyps: 18 years and older IgE-mediated food allergy: 1 year and older
Prescriber Restriction	Asthma, Chronic Urticaria, Nasal Polyps: None IgE-mediated food allergy: Prescribed or in consultations with Allergist or Immunologist
Coverage Duration	12 months
Other Requirements & Information Needed for Continuation of Care	Note: Omalizumab (Xolair™) is available for self-administration in the form of a prefilled syringe and is typically administered by the member or a caregiver at home. As soon as the maintenance dose is established and member or caregiver can be trained for self-administration, Xolair™ prefilled syringes can be provided to the member by a pharmacy for administration at home whenever possible.

Requirements for Omalizumab (Xolair™ Prefilled Syringe & Xolair™ Vial)

Medical Billing:

Dose limits & billing requirements (approved TAR is required):

HCPCS	Description	Dosing, Units
J2357	Injection, Omalizumab, 5 mg (Nucala™ prefilled syringes & Nucala™ vials)	Asthma: • ≥ 12 yrs: o 150 mg – 375 mg, every 2-4 weeks o Dose and frequency determined by initial pretreatment IgE level and body weight (kg) • 6-11 yrs: o 75 mg -375 mg every 2-4 weeks o Dose and frequency determined by initial total IgE level and body weight (kg) Chronic idiopathic urticaria: • ≥ 12 yrs: 150 – 300 mg every 4 weeks Nasal Polyps: • ≥ 18 yrs: 75 mg – 600 mg every 2-4 weeks • Dose and frequency determined by initial pretreatment IgE level and wt (kg) Food Allergy: • ≥ 1 yr: o 75 mg – 600 mg, every 2-4 weeks o Dose and frequency determined by initial pretreatment IgE level and body weight (kg)

Requirements for Lovotibeglogene Autotemcel (Lyfgenia)

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	The treatment of patients 12 years of age or older with sickle cell disease and a history of vaso-occlusive events (VOEs).
Exclusion Criteria	1. Off-label use 2. Prior use exagamglogene autotemcel (Casgevy) or lovotibeglogene autotemcel (Lyfgenia) or other gene therapy 3. Prior receipt of an allogeneic transplant 4. Positive HIV test 5. Inability to receive RBC transfusions
Required Medical Information	1) Genetic testing to confirm severe sickle cell disease genotype: β^s/β^s, β^s/β^0, or β^s/β^+ 2) Documentation that the member has had at least 4 severe vaso-occlusive events (VOE) in the prior 24 months as defined below, while receiving appropriate supportive care (e.g. pain management plan, hydroxyurea) a. No medically determined cause other than a vaso-occlusion b. Event that requires at least one of the following: i. A visit to a medical facility and administration of pain medications (opioids or intravenous non-steroidal anti-inflammatory drugs [NSAIDs]) or RBC transfusions ii. OR a ≥ 24-hour hospital or Emergency Room (ER) observation unit visit iii. OR at least 2 visits to a day unit or ER over 72 hours with both visits requiring intravenous treatment. iv. OR acute chest syndrome v. OR splenic sequestration vi. OR Priapism lasting >2 hours OR 4 priapism episodes that require a visit to a medical facility (without inpatient admission) are sufficient to meet criterion 3) Documentation that the member has failed hydroxyurea (HU) at any point in the past or must have intolerance to HU. Failure is defined as >1 VOE or ≥1 Acute Chest Syndrome after HU has been prescribed for at least 6 months 4) Reasons why preferred gene therapy option for sickle cell disease, exagamglogene autotemcel (Casgevy), cannot be used 5) Human immunodeficiency virus (HIV-1 and HIV-2), Hepatitis B virus (HBV), and Hepatitis C virus (HCV) testing, as well as documentation that the member does not have a clinically significant and active other viral, bacterial, fungal or parasitic infection 6) Confirmation that hematopoietic stem cell transplantation is appropriate for the patient and documentation of the following: a. Karnofsky performance status of ≥ 60 (≥16 years of age) or a Lansky performance status of ≥60 (<16 years of age) b. No advanced liver disease; severe hepatic fibrosis or cirrhosis c. eGFR is ≥ 60 ml/min/1.73m^2 d. No cardiomyopathy or severe congestive heart failure (NYHA class III or IV) and baseline LVEF is ≥45% e. Lung diffusing capacity for carbon monoxide (DLCO) is ≥40%, and baseline O2 saturation ≥85% without supplemental oxygen (excluding

Requirements for Lovotibeglogene Autotemcel (Lyfgenia)

	periods of SCD crisis, severe anemia or infection) f. No clinically significant pulmonary hypertension at baseline g. WBC count ≥$3x10^9$/L and platelet count ≥$50x10^9$/L (unless related to hypersplenism) h. Documentation that the member does not have any history of severe cerebral vasculopathy: defined by overt or hemorrhagic stroke; abnormal transcranial Doppler [≥200 cm/sec] needing chronic transfusion; or occlusion or stenosis in the polygon of Willis; or presence of Moyamoya disease. 7) Confirmation that the member does not have an available 10/10 HLA matched related HSCT donor 8) Treatment and medications required for mobilization, and myeloablative conditioning have been approved: a. Plerixafor (Mozobil™, TAR required), for mobilization b. Busulfan (TAR required), for myeloablative conditioning 9) Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both denials and approvals (ie denials for medical necessity).
Age Restriction	12 years and older
Prescriber Restriction	Hematologist or Transplant Specialist at a Qualified Treatment Center
Coverage Duration	FDA labeling: Once per lifetime, approval should be for a 12 month duration
Other Requirements & Information	Limited to once per lifetime treatment. There will be no renewals or retreatment requests approved.

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J3590	Unclassified biologicals; lovotibeglogene autotemcel (Lyfgenia™)	The minimum recommended dose is 3×10^6 CD34+ cells/kg

Currently in California, there is only one planned qualified treatment center: Lucile Salter Packard Children's Hospital at Stanford; Palo Alto.

Requirements for Exagamglogene Autotemcel (Casgevy)

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	• The treatment of sickle cell disease (SCD) in patients 12 years and older with recurrent vaso-occlusive crises (VOCs). • The treatment of transfusion-depended β-thalassemia (TDT) in patients 12 years and older
Exclusion Criteria	1) Off-label use 2) Prior use of lovotibeglogene autotemcel (Lyfgenia) or exagamglogene autotemcel (Casgevy) or other gene therapy 3) Prior receipt of HSCT 4) For Sickle Cell Disease only: Inability to receive RBC transfusions
Required Medical Information	<u>Requirements for all indications:</u> 1) Confirmation that hematopoietic stem cell transplantation is appropriate for the patient and documentation of the following: a. Karnofsky performance status of ≥ 60 (≥16 years of age) or a Lansky performance status of ≥60 (<16 years of age) b. No advanced liver disease; severe hepatic fibrosis or cirrhosis c. eGFR is ≥ 60 ml/min/1.73m^2 d. No cardiomyopathy or severe congestive heart failure (NYHA class III or IV) and baseline LVEF is ≥45% e. Lung diffusing capacity for carbon monoxide (DLCO) is ≥40%, and baseline O2 saturation ≥85% without supplemental oxygen (excluding periods of SCD crisis, severe anemia or infection) f. No clinically significant pulmonary hypertension at baseline g. WBC count ≥3x10^9/L and platelet count ≥50x10^9/L (unless related to hypersplenism) h. Documentation that the member does not have any history of severe cerebral vasculopathy: defined by overt or hemorrhagic stroke; abnormal transcranial Doppler [≥200 cm/sec] needing chronic transfusion; or occlusion or stenosis in the polygon of Willis; or presence of Moyamoya disease. 2) Confirmation that the member does not have an available 10/10 HLA matched related HSCT donor 3) Human immunodeficiency virus (HIV-1 and HIV-2), Hepatitis B virus (HBV), and Hepatitis C virus (HCV) testing, as well as documentation that the member does not have a clinically significant and active other viral, bacterial, fungal or parasitic infection 4) Treatment and medications required for mobilization, and myeloablative conditioning have been approved: a. Plerixafor (Mozobil™, TAR required), for mobilization b. Busulfan (TAR required), for myeloablative conditioning 5) Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both denials and approvals (ie denials for medical necessity). <u>Additional Requirements for Sickle Cell Disease</u> 1) Genetic testing to confirm severe sickle cell disease genotype: β^s/β^s, β^s/β^0, or β^s/β^+

Requirements for Exagamglogene Autotemcel (Casgevy)

	2) Documentation that the member has had at least 4 severe vaso-occlusive events (VOE) in the prior 24 months as defined below while receiving appropriate supportive care (e.g. pain management plan, hydroxyurea) a. No medically determined cause other than a vaso-occlusion b. Event that requires at least one of the following: i. A visit to a medical facility and administration of pain medications (opioids or intravenous non-steroidal anti-inflammatory drugs [NSAIDs]) or RBC transfusions ii. OR a ≥ 24-hour hospital or Emergency Room (ER) observation unit visit iii. OR at least 2 visits to a day unit or ER over 72 hours with both visits requiring intravenous treatment. iv. OR acute chest syndrome v. OR splenic sequestration vi. OR Priapism lasting >2 hours OR 4 priapism episodes that require a visit to a medical facility (without inpatient admission) are sufficient to meet criterion 3) Documentation that the member has failed hydroxyurea (HU) at any point in the past or must have intolerance to HU. Failure is defined as >1 VOE or ≥1 ACS after HU has been prescribed for at least 6 months <u>Additional Requirements for Transfusion Dependent Beta Thalassemia</u> 1) Genetic testing to confirm beta thalassemia 2) Documentation of transfusion dependence as evidenced by one of the following a. A history of at least 100 mL/kg/year in the prior 2 years OR b. 10 units/year of packed RBC transfusions in the prior 2 years 3) No severe iron overload in heart or liver or endocrine systems, evaluated within the last 6 months
Age Restriction	FDA indication: 12 years and older
Prescriber Restriction	Hematologist or Transplant Specialist at an Authorized Treatment Center
Coverage Duration	FDA labeling: Once per lifetime, approval will allow a 12 month duration
Other Requirements & Information	Limited to once per lifetime treatment. There will be no renewals or retreatment requests approved.

<u>Medical Billing:</u>

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J3590	Unclassified biologicals; exagamglogene autotemcel (Casgevy™)	The minimum recommended dose is 3×10^6 CD34+ cells/kg

Currently in California, there is only one planned authorized treatment center City of Hope National Medical Center; Duarte (near Los Angeles).

Requirements for Chimeric Antigen Receptor T-cell (CAR-T) Therapy

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer.

PA Criteria	Criteria Details
Covered Uses	Per FDA approved indications included in the product labeling. CAR-T immunotherapy products included in this criteria: • Idecabtagene vicleucel (Abecma™) • Lisocabtagene maraleucel (Breyanzi™) • Ciltacabtagene autoleucel (Carvykti™) • Tisagenlecleucel (Kymriah™) • Brexucabtagene autoleucel (Tecartus™) • Axicabtagene ciloleucel (Yescarta™)
Exclusion Criteria	• CAR-T will not be approved for use as first-line therapy. • Concurrent or prior treatment with another CAR-T immunotherapy. • Concurrent use with a chemotherapy regimen (excluding the necessary lymphodepleting regimen). • CNS disorders or CNS malignancy/metastasis • Active infectious disease. • Inability to remain in the vicinity of the REMS certified facility for a minimum of 4 weeks. • ECOG grade 4 or worse.
Required Medical Information	• Histologically confirmed diagnosis of one of the FDA approved indication for which therapy is being requested to treat. • Clinic notes documenting history and course of illness, including response to previous therapies. • Documentation that member does not have active infection, and the recommended screenings in the package labeling, or in treatment guidelines, have been or will be performed for (including but not limited to): Hepatitis B, Hepatitis C, and HIV. • Documentation that member does not have an autoimmune disease or graft-vs-host disease requiring immunosuppression. • Documentation that member will undergo the recommended lymphodepleting regimen prior to CAR-T treatment (cyclophosphamide + fludarabine or appropriate alternative as recommended by package labeling or treatment guidelines). • Documentation that member is able to remain in the vicinity of the certified healthcare facility for at least 4 weeks post-infusion. • Member's current bone marrow, cardiac, pulmonary, liver, and renal function (all organ function must be adequate). • ECOG (Eastern Cooperative Oncology Group) performance status grade. • Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both approvals and denials not meeting medical necessity.
Age Restriction	See prescriber information per drug specific approval information. For most indications, CAR-T may be approved for members aged 18 or older. Noted exception for tisagenlecleucel (Kymriah™) when used for the treatment of precursor acute lymphoblastic leukemia which is limited to members aged 25 years and younger on the date of the infusion (date of service), not previously treated with any gene therapy.
Prescriber Restriction	Prescribed by a hematologist or oncologist

Requirements for Chimeric Antigen Receptor T-cell (CAR-T) Therapy

Coverage Duration	A 3-month treatment window on the authorization but limited to 1 dose only per lifetime.
Other Requirements & Information	Additional required information per FDA-approved indication, at time of publication. **Multiple myeloma, relapsed or refractory:** FDA-approved CAR-T therapies with this indication**: Abecma™, Carvykti™.** Additional information required with request: • Documentation of treatment failure (either due to intolerable adverse reaction or lack of efficacy) with at least 4 prior therapies, with at least one from each mechanism of action group listed below included among the prior 4 lines of treatment: a) An anti-CD38 monoclonal antibody: daratumumab (Darzalex), daratumumab-hyaluronidase (Darzalex Faspro), or isatuximab (Sarclisa) b) A proteasome inhibitor: bortezomib (Velcade), carfilzomib (Kyprolis), or ixazomib (Ninlaro) c) An immunomodulatory agent: lenalidomide (Revlimid), thalidomide (Thalomid, accepted off-label use), or pomalidomide (Pomalyst) **Large B-cell lymphoma, relapsed or refractory:** FDA-approved CAR-T therapies with this indication: **Breyanzi™, Kymriah™, Yescarta™.** Additional information required with request: • A confirmed diagnosis of large B-cell lymphoma, including ANY of the following types: ▪ Diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from follicular lymphoma or transformed follicular lymphoma-TFL) ▪ Primary mediastinal large B-cell lymphoma ▪ High grade B-cell lymphoma • Documentation of treatment of large B-cell lymphoma in adults that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy OR • Member has evidence of disease progression after two or more chemotherapy regimens recommended as first or second-line in compendia such as NCCN which may or may not have included therapy supported by allogeneic stem cell transplant. • Limitations of use: Not indicated for treatment of primary CNS lymphoma. **Follicular lymphoma, relapsed or refractory:** FDA-approved CAR-T therapies with this indication: **Kymriah™, Yescarta™.** • Documentation of treatment of relapsed or refractory follicular lymphoma in adults after two or more chemotherapy regimens recommended as first or second line in compendia such as NCCN that includes a combination of an anti-CD20 monoclonal antibody (e.g. rituximab, obinutuzumab) and an alkylating agent (e.g. bendamustine, cyclophosphamide, chlorambucil) **Acute lymphoblastic leukemia (ALL), B-cell precursor, relapsed or refractory:** FDA-approved CAR-T therapies with this indication for children and young adults up to 25 years of age: **Kymriah™**. FDA-approved CAR-T therapies with this indication for adults 18 years and older: **Tecartus™**. • Documentation of treatment of relapsed or refractory B-cell precursor ALL. • Member has a confirmed diagnosis of B-cell precursor ALL and the

members condition meets ONE of the additional criteria, as specified below in either item 1 or item 2:

1. Second or later relapse B-cell precursor ALL after failing at least two lines of adequate treatment (with relapse defined as the reappearance of leukemia cells in the bone marrow or peripheral blood after complete remission with chemotherapy and/or allogeneic cell transplant) OR
2. Refractory B-cell precursor ALL with refractory defined as failure to obtain complete response with induction therapy (with second or later bone marrow relapse, bone marrow relapse after allogeneic stem cell transplant, or primary refractory or chemorefractory after relapse)

- Members with Ph+ ALL require documentation of failure of 2 tyrosine kinase inhibitors (e.g., imatinib, dasatinib, nilotinib, bosutinib, ponatinib) at up to maximally indicated doses is required, unless contraindicated or clinically significant adverse effects are experienced, PHC prior authorization may be required for tyrosine kinase inhibitors.

Mantle cell lymphoma, relapsed or refractory:

FDA-approved CAR-T therapies with this indication: **Tecartus™.**

- Documentation of treatment of relapsed or refractory mantle cell lymphoma (MCL) in adults.
- Documentation of prior treatment with, or intolerance or contraindication to, all of the following:
  a) Anthracycline or bendamustine containing chemotherapy
  b) An anti-CD20 antibody (rituximab)
  c) BTK (bruton tyrosine kinase) inhibitor (acalabrutinib, ibrutinib, zanubrutinib).

Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*