Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: 05/01/2021**
Policy Number: PA.CP.PHAR.483	**Effective Date: 04/2021** **Revision Date: 04/2021**
Policy Name: Lisocabtagene Maraleucel (Breyanzi)	

Type of Submission – Check all that apply:

- ✓ **New Policy**
- ☐ **Revised Policy***
- ☐ **Annual Review - No Revisions**
- ☐ **Statewide PDL -** *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

Name of Authorized Individual (Please type or print): **Auren Weinberg, MD**	**Signature of Authorized Individual:** 

Clinical Policy: Lisocabtagene Maraleucel (Breyanzi)

Reference Number: PA.CP.PHAR.483
Effective Date: 04/2021
Last Review Date: 04/2021

Revision Log

Description
Lisocabtagene maraleucel (Breyanzi®) is a CD19-directed genetically modified autologous T-cell immunotherapy.

FDA Approved Indication(s)
Breyanzi is indicated for the treatment of adult patients with relapsed or refractory large B-cell lymphoma (LBCL) after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from indolent lymphoma), high-grade B-cell lymphoma, primary mediastinal large B-cell lymphoma, and follicular lymphoma grade 3B.

Limitation of use: Breyanzi is not indicated for the treatment of patients with primary central nervous system (CNS) lymphoma.

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 PA Health & Wellness® that Breyanzi is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Large B-Cell Lymphoma* (must meet all)**:**
**Only for initial treatment dose; subsequent doses will not be covered.*

1. Diagnosis of one of the following LBCL (a–f);
   a. DLBCL;
   b. Primary Mediastinal Large B Cell Lymphoma (PMBCL);
   c. Transformed Follicular Lymphoma (TFL) to DLBCL;
   d. Transformed Nodal Marginal Zone lymphoma (MZL) to DLBCL;
   e. High-grade B-cell lymphomas with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma) or high-grade B-cell lymphomas, not otherwise specified;
   f. Monomorphic post-transplant lymphoproliferative disorders (B-cell type);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Disease is refractory or member has relapsed after ≥ 2 lines of systemic therapy that includes an anti-CD20 therapy (e.g., rituximab) and one anthracycline-containing regimen (e.g., doxorubicin);*****
   **Prior authorization may be required for rituximab*
5. Member does not have primary CNS disease;

6. Member has not previously received treatment with CAR T-cell immunotherapy (e.g., Kymriah™, Yescarta™);
7. Breyanzi is not prescribed concurrently with other CAR T-cell immunotherapy (e.g., Kymriah, Yescarta);
8. Dose does not exceed 110 x 10^6 chimeric antigen receptor (CAR)-positive viable T cells.

Approval duration: 3 months *(1 dose only, with 4 doses of tocilizumab (Actemra) at up to 800 mg per dose)*

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53

II. Continued Therapy

A. Large B-Cell Lymphoma

1. Continued therapy will not be authorized as Breyanzi is indicated to be dosed one time only.

Approval duration: Not applicable

B. Other diagnoses/indications

1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53

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 – PA.CP.PMN.53;

B. Primary CNS disease.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALC: absolute lymphocyte count
CAR: chimeric antigen receptor
CNS: central nervous system
CRS: cytokine release syndrome
DLBCL: diffuse large B-cell lymphoma
FDA: Food and Drug Administration
LBCL: large B-cell lymphoma

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
First-Line Treatment Regimens		
RCHOP (Rituxan® (rituximab), cyclophosphamide, doxorubicin, vincristine, prednisone)	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
RCEPP (Rituxan® (rituximab), cyclophosphamide, etoposide, prednisone, procarbazine)	Varies	Varies
RCDOP (Rituxan® (rituximab), cyclophosphamide, liposomal doxorubicin, vincristine, prednisone)	Varies	Varies
DA-EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicine) + Rituxan® (rituximab)	Varies	Varies
RCEOP (Rituxan® (rituximab), cyclophosphamide, etoposide, vincristine, prednisone)	Varies	Varies
RGCVP (Rituxan®, gemcitabine, cyclophosphamide, vincristine, prednisone)	Varies	Varies
Second-Line Treatment Regimens		
Bendeka® (bendamustine) ± Rituxan® (rituximab)	Varies	Varies
CEPP (cyclophosphamide, etoposide, prednisone, procarbazine) ± Rituxan® (rituximab)	Varies	Varies
CEOP (cyclophosphamide, etoposide, vincristine, prednisone) ± Rituxan® (rituximab)	Varies	Varies
DA-EPOCH ± Rituxan® (rituximab)	Varies	Varies
GDP (gemcitabine, dexamethasone, cisplatin) ± Rituxan® (rituximab)	Varies	Varies
gemcitabine, dexamethasone, carboplatin ± Rituxan® (rituximab)	Varies	Varies
GemOx (gemcitabine, oxaliplatin) ± Rituxan® (rituximab)	Varies	Varies
gemcitabine, vinorelbine ± Rituxan® (rituximab)	Varies	Varies
lenalidomide ± Rituxan® (rituximab)	Varies	Varies
Rituxan® (rituximab)	Varies	Varies
DHAP (dexamethasone, cisplatin, cytarabine) ± Rituxan® (rituximab)	Varies	Varies
DHAX (dexamethasone, cytarabine, oxaliplatin) ± Rituxan® (rituximab)	Varies	Varies
ESHAP (etoposide, methylprednisolone, cytarabine, cisplatin) ± Rituxan® (rituximab)	Varies	Varies
ICE (ifosfamide, carboplatin, etoposide) ± Rituxan® (rituximab)	Varies	Varies
MINE (mesna, ifosfamide, mitoxantrone, etoposide) ± Rituxan® (rituximab)	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): none reported
- Boxed warning(s): cytokine release syndrome and neurologic toxicities

Appendix D: General Information

- Patients with primary CNS disease were excluded from the TRANSCEND NHL 001 trial. For primary CNS lymphoma, NCCN treatment guidelines for CNS cancers recommend a high-dose methotrexate induction based regimen or whole brain radiation therapy, and consolidation therapy with high-dose chemotherapy with stem cell rescue, high-dose cytarabine with or without etoposide, low dose whole brain radiation therapy, or continuation with monthly high-dose methotrexate-based regimen.
- In the TRANSCEND NHL 001 trial, three of six patients in the efficacy-evaluable set with secondary CNS lymphoma achieved a complete response.
- No prespecified threshold for blood counts, including absolute lymphocyte count, was required for enrollment in the TRANSCEND NHL 001 trial.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
LBCL	Target dose: 50 to 110 x 10^6 CAR-positive viable T cells	110 x 10^6 CAR-positive viable T cells

VI. Product Availability

Single-dose 5 mL vial: frozen suspension of genetically modified autologous T-cells labeled for the specific recipient

VII. References

1. Breyanzi Prescribing Information. Bothell, WA: Juno Therapeutics, Inc.; February 2021. Available at: https://packageinserts.bms.com/pi/pi_breyanzi.pdf. Accessed February 8, 2021.
2. ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). Identifier NCT02631044, Study Evaluating the Safety and Pharmacokinetics of JCAR017 in B-cell Non-Hodgkin Lymphoma (TRANSCEND-NHL-001); 23 December 2019. Available at: https://clinicaltrials.gov/ct2/show/NCT02631044?term=lisocabtagene&draw=2&rank=4. Accessed March 24, 2020.
3. Abramson JS, Palomba ML, Gordon LI, et al. Lisocabtagene maraleucel for patients with relapsed or refractory large B-cell lymphomas (TRANSCEND NHL 001): a multicentre seamless design study. Lancet. 2020 September 19; 396: 839-852.
4. National Comprehensive Cancer Network. B-cell Lymphomas Version 2.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed February 16, 2021.
5. National Comprehensive Cancer Network Drug and Biologics Compendium. Available at http://www.nccn.org/professionals/drug_compendium. Accessed February 16, 2021.
6. National Comprehensive Cancer Network. Central Nervous System Cancers Version 3.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf. Accessed February 16, 2021.

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
TBD	Lisocabtagene Maraleucel, Autologous Anti-CD19 CAR T Cells, Including Leukapheresis And Dose Preparation Procedures, Per Infusion

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	04/2021	