Clinical Policy: Teclistamab-cqyv (Tecvayli)

Reference Number: LA.PHAR.611
Effective Date: 05.10.24
Last Review Date: 03.09.26~~5.14.25~~ Coding Implications
Line of Business: Medicaid Revision Log

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

****Please note: This policy is for medical benefit****

Description
Teclistamab-cqyv (Tecvayli™) is a humanized recombinant immunoglobulin G4-proline, alanine, alanine (IgG4-PAA) antibody, and a bispecific B-cell maturation antigen (BCMA)-directed CD3 T-cell engager.

FDA Approved Indication(s)
Tecvayli is indicated for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least four prior lines of therapy, including a proteasome inhibitor (PI), an immunomodulatory agent (IMiD), and an anti-CD38 monoclonal antibody.

This indication is approved under accelerated approval based on response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).

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 Louisiana Healthcare Connections® that Tecvayli is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Multiple Myeloma (must meet all)**:**

1. Diagnosis of relapsed or refractory multiple myeloma;
2. Prescribed by or in consultation with a hematologist or an oncologist;
3. Age ≥ 18 years;
~~4. Tecvayli is prescribed as monotherapy;~~
4. Prescribed in one of the following ways (a or b):
   a. As monotherapy, and member has received or has documented intolerance to ≥ 4 prior lines of therapy (*see Appendix B for examples*) that include all of the following (i, ii, and iii):
      i. One proteasome inhibitor (e.g., bortezomib, Kyprolis®, Ninlaro®);
      ii. One immunomodulatory agent (e.g., Revlimid®, pomalidomide, Thalomid®);
      iii. One anti-CD38 antibody (e.g., Darzalex®/Darzalex Faspro™, Sarclisa®);

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b. In combination with Talvey®, and member has received ≥ 3 prior lines of therapy (*see Appendix B for examples*);

**Prior authorization may be required*

5. One of the following (a or b):
   a. Member has measurable disease as evidenced by one of the following assessed within the last 28 days (i, ii, or iii):
      i. Serum M-protein ≥ 0.5 g/dL;
      ii. Urine M-protein ≥ 200 mg/24 h;
      iii. Serum free light chain (FLC) assay: involved FLC level ≥ 10 mg/dL (100 mg/L) provided serum kappa lambda FLC ratio is abnormal;
   b. Member has progressive disease, as defined by the IMWG response criteria (see *Appendix D*), assessed within 60 days following the last dose of the last anti-myeloma drug regimen received;

~~6. Member has received or has documented intolerance to ≥ 4 prior lines of therapy (*see Appendix B for examples*) that include all of the following (a, b, and c):~~
   ~~a. One proteasome inhibitor (e.g., bortezomib, Kyprolis®, Ninlaro®);~~
   ~~b. One immunomodulatory agent (e.g., Revlimid®, pomalidomide, Thalomid®);~~
   ~~c. One anti-CD38 antibody (e.g., Darzalex®/Darzalex Faspro™, Sarclisa®);~~

~~**Prior authorization may be required*~~

~~7.~~6. Member does not have a known active central nervous system (CNS) involvement (e.g., seizure, cerebrovascular ischemia) or exhibits clinical signs of meningeal involvement of multiple myeloma;

~~8.~~7. Dose does not exceed all of the following (a, b, c, d, and e):*
   a. Day 1: 0.06 mg/kg;
   b. Day 4: 0.3 mg/kg;
   c. Day 7: 1.5 mg/kg;
   d. Day 8 and thereafter: 1.5 mg/kg per week;
   e. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label dose use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: ~~6~~ 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 LA.PMN.255
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 LA.PMN.53.

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II. Continued Therapy

A. Multiple Myeloma (must meet all)**:**

1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Tecvayli 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, b, or ~~b~~c):*
   a. New dose does not exceed 1.5 mg/kg every 2 weeks;
   ~~a.~~b. New dose does not exceed 1.5 mg/kg per week, and documentation supports that member has not achieved and maintained a complete response or better for a minimum of 6 months;
   ~~b.~~c. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label dose 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 LA.PMN.255
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 LA.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 – LA.PMN.53;

B. Active or prior history of CNS involvement with myeloma (e.g., seizures, cerebrovascular ischemia) or exhibit clinical signs of meningeal involvement of multiple myeloma.

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IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

BCMA: B-cell maturation antigen
CNS: central nervous system
CRS: cytokine release syndrome
FDA: Food and Drug Administration
ICANS: immune effector cell-associated neurotoxicity syndrome
IMiD: immunomodulatory drug
IMWG: International Myeloma Working Group
PI: proteasome inhibitor

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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
MM: regimens containing proteasome inhibitors, immunomodulatory agents and/or anti-CD38 monoclonal antibodies (examples – NCCN)		
bortezomib~~/Revlimid® (/~~ lenalidomide~~)/~~ (Revlimid®) or pomalidomide or Thalomid (thalidomide) / dexamethasone	Varies	Varies
~~bortezomib/cyclophosphamide/dexamethasone~~	~~Varies~~	~~Varies~~
~~bortezomib/doxorubicin (or liposomal doxorubicin)/ dexamethasone~~	~~Varies~~	~~Varies~~
~~Kyprolis® (carfilzomib) Revlimid® (lenalidomide)/ dexamethasone~~	~~Varies~~	~~Varies~~
~~Kyprolis® (carfilzomib)/cyclophosphamide/ dexamethasone~~	~~Varies~~	~~Varies~~
Kyprolis® (carfilzomib – weekly or twice weekly~~)/~~) / dexamethasone	Varies	Varies
~~Ninlaro® (ixazomib)/Revlimid® (~~Kyprolis (carfilzomib) / lenalidomide~~)/~~ (Revlimid) / dexamethasone	Varies	Varies
~~Ninlaro® (ixazomib)/dexamethasone~~	~~Varies~~	~~Varies~~
~~Ninlaro® (ixazomib)/pomalidomide/dexamethasone~~	~~Varies~~	~~Varies~~
~~bortezomib/dexamethasone~~	~~Varies~~	~~Varies~~
~~bortezomib/Thalomid® (thalidomide)/dexamethasone~~	~~Varies~~	~~Varies~~
~~cyclophosphamide/Revlimid® (~~Ninlaro (ixazomib) / lenalidomide~~)/~~ (Revlimid) / dexamethasone	Varies	Varies
~~Revlimid® (lenalidomide)/dexamethasone~~	~~Varies~~	~~Varies~~
~~VTD-PACE (dexamethasone/Thalomid®(thalidomide) /cisplatin/doxorubicin/cyclophosphamide/etoposide/ bortezomib)~~	~~Varies~~	~~Varies~~
~~Revlimid® (lenalidomide)/low-dose dexamethasone~~	~~Varies~~	~~Varies~~

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Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
~~Darzalex® (daratumumab) or Darzalex Faspro™ (daratumumab/hyaluronidase-fihj)/bortezomib/ melphan/prednisone~~	~~Varies~~	~~Varies~~
Darzalex® (daratumumab) ~~or Darzalex Faspro™ (daratumumab/hyaluronidase-fihj)~~/ bortezomib~~/~~ / dexamethasone ± Thalomid (thalidomide)	Varies	Varies
Darzalex® (daratumumab) ~~or Darzalex Faspro™ (daratumumab/hyaluronidase-fihj)/Revlimid® (~~/ lenalidomide~~)~~/ (Revlimid) / dexamethasone	Varies	Varies
~~Darzalex® (daratumumab) or Darzalex Faspro™ (daratumumab/hyaluronidase-fihj)~~	~~Varies~~	~~Varies~~
~~Darzalex® (daratumumab) or Darzalex Faspro™ (daratumumab/hyaluronidase-fihj)/pomalidomide/ dexamethasone~~	~~Varies~~	~~Varies~~
~~Empliciti® (elotuzumab)/Revlimid® (lenalidomide)/ dexamethasone~~	~~Varies~~	~~Varies~~
~~Empliciti® (elotuzumab)/bortezomib/dexamethasone~~	~~Varies~~	~~Varies~~
~~Empliciti®(elotuzumab)/pomalidomide/dexamethasone~~	~~Varies~~	~~Varies~~
~~bendamustine/bortezomib/dexamethasone~~	~~Varies~~	~~Varies~~
~~bendamustine/Revlimid® (lenalidomide)/dexamethasone~~	~~Varies~~	~~Varies~~
~~panobinostat/bortezomib/dexamethasone~~	~~Varies~~	~~Varies~~
~~panobinostat/Kyprolis® (carfilzomib)~~	~~Varies~~	~~Varies~~
~~panobinostat/Revlimid® (lenalidomide)/dexamethasone~~	~~Varies~~	~~Varies~~
~~pomalidomide/cyclophosphamide/dexamethasone~~	~~Varies~~	~~Varies~~
~~pomalidomide/dexamethasone~~	~~Varies~~	~~Varies~~
~~pomalidomide/bortezomib/dexamethasone~~	~~Varies~~	~~Varies~~
~~pomalidomide/Kyprolis® (carfilzomib)/dexamethasone~~	~~Varies~~	~~Varies~~
~~Sarclisa® (isatuximab-irfc)/pomalidomide/dexamethasone~~	~~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 (CRS) with life-threatening and/or fatal reactions, and neurologic toxicity, including immune effector cell-associated neurotoxicity syndrome (ICANS)

Appendix D: General Information

- Due to the risks of CRS, patients should be hospitalized for 48 hours after administration of all doses within the step-up dosing schedule including the first maintenance dose.

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Subsequent weekly maintenance doses are managed on outpatient basis according to the Tecvayli REMS program (*see Appendix E for more details on REMS Program*).

- In the MajesTEC-1 trial, 100% of enrolled patients reported having an adverse event, of which 94.5% were grade 3 or 4. The most common hematologic adverse events were neutropenia (70.9%), anemia (52.1%), and thrombocytopenia (44.0%). The most common non-hematologic adverse events were diarrhea (28.5%), fatigue (27.9%), and nausea (27.3%).
- In the MajesTEC-1 trial, 72.1% of participants experienced any grade CRS, and 14.5% of participants experienced any grade ICANS. Both toxicities were managed with supportive measures that included administration of tocilizumab (in 60/119 patients with CRS, and 3/24 patients with ICANS), low-flow oxygen by nasal cannula, glucocorticoids, levetiracetam, and gabapentin.
- In the MajesTEC-1 trial, five deaths were considered to have been related to Tecvayli treatment including one death resulting from progressive multifocal leukoencephalopathy, two deaths related to Covid-19, one death related to hepatic failure, and one death related to streptococcal pneumonia. Subjects positive for hepatitis B, hepatitis C, and/or HIV were excluded from the trial. Prior to treatment with Tecvayli, initiation of antiviral prophylaxis to prevent herpes zoster reactivation is recommended.
- The IMWG response criteria for multiple myeloma definition of progressive disease requires only one of the following:
  - Increase of 25% from lowest response value in any of the following:
    - Serum M-component (absolute increase must be ≥ 0.5 g/dL), and/or
    - Urine M-component (absolute increase must be ≥ 200 mg/24 h), and/or
    - Only in patients without measurable serum and urine M-protein levels: the difference between involved and uninvolved FLC levels (absolute increase must be > 10 mg/dL)
    - Only in patients without measurable serum and urine M protein levels and without measurable disease by FLC levels, bone marrow plasma cell percentage irrespective of baseline status (absolute increase must be ≥ 10%)
  - Appearance of a new lesion(s), ≥ 50% increase from nadir in SPD (sum of the products of the maximal perpendicular diameters of measured lesions) of > 1 lesion, or ≥ 50% increase in the longest diameter of a previous lesion > 1 cm in short axis
  - ≥ 50% increase in circulating plasma cells (minimum of 200 cells per µL) if this is the only measure of disease
- The Standard IMWG response criteria (per NCCN) define complete response as the negative immunofixation on the serum and urine and disappearance of any soft tissue plasmacytomas and < 5% plasma cells in bone marrow aspirates.

Appendix E: Tecvayli REMS Program Information

- Tecvayli is available only through a restricted REMS program due to the risk of cytokine release syndrome and neurologic toxicity, including ICANS.
- Prescribers are required to:
  1) obtain certification with the program by enrolling and completing training;

2) counsel patients about the risks associated with Tecvayli therapy;
3) provide patients with patient wallet card.

- Dispensers are required to:
  1) obtain certification with the program;
  2) verify prescriber certification status with the program prior to dispensing the product.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Multiple myeloma	Step-up Dosing Schedule[a]: • Day 1: 0.06 mg/kg subcutaneously (step-up dose 1) • Day 4[b]: 0.3 mg/kg subcutaneously (step-up dose 2) • Day 7[c]: 1.5 mg/kg subcutaneously (first treatment dose) Weekly Dosing Schedule[a]: • 1.5 mg/kg subcutaneously once weekly (one week after first treatment dose and weekly thereafter) Biweekly Dosing Schedule[a]: • 1.5 mg/kg subcutaneously every two weeks for patients who have achieved and maintained a complete response or better for a minimum of 6 months	1.5 mg/kg per week subcutaneously

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[a] *Refer to prescribing information Table 2 for recommendations on restarting therapy due to dose delays.*
[b] *Step-up dose 2 may be given between 2 to 4 days after step-up dose 1 and may be given up to 7 days after step-up dose 1 to allow for resolution of adverse reactions.*
[c] *First treatment dose may be given between 2 to 4 days after step-up dose 2 and may be given up to 7 days after step-up dose 2 to allow for resolution of adverse reactions.*

VI. Product Availability

Solution for subcutaneous injection in a single-dose vial:

- 30 mg/3 mL (10 mg/mL) used for step-up doses 1 and 2
- 153 mg/1.7 mL (90 mg/mL) used for treatment doses

VII. References

1. Tecvayli Prescribing Information. Horsham, PA: Janssen Biotech, Inc.; ~~May 2024~~August 2025. Available at: https://www.janssenlabels.com/package-insert/product-monograph/prescribing-information/TECVAYLI-pi.pdf. Accessed October ~~31, 2024~~21, 2025.
2. ClinicalTrials.gov. A phase 1, first-in-human, open-label, dose escalation study of teclistamab, a humanized BCMA x CD3 bispecific antibody in subjects with relapsed or refractory multiple myeloma. Available at: https://www.clinicaltrials.gov/ct2/show/NCT03145181. Accessed November 10, 2022.

3. ClinicalTrials.gov. A phase 1/2, first-in-human, open-label, dose escalation study of teclistamab, a humanized BCMA x CD3 bispecific antibody, in subjects with relapsed or refractory multiple myeloma. Available at: https://clinicaltrials.gov/ct2/show/NCT04557098. Accessed November 10, 2022.
4. Touzeau C, Krishnan AY, Moreau P, et al. Efficacy and safety of teclistamab in patients with relapsed/refractory multiple myeloma after BCMA-targeting therapies. Blood. Published online August 20, 2024.
5. Girgis S, Lin SXW, Pillarisetti K, et al. Translational modeling predicts efficacious therapeutic dosing range of teclistamab for multiple myeloma. Target Oncol. 2022;17(4):433-439.
6. Moreau P, Garfall AL, van de Donk NWCJ, et al. Teclistamab in relapsed or refractory multiple myeloma. N Engl J Med. 2022;387(6):495-505.
7. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed November 30, 2025.
~~7.~~8. National Comprehensive Cancer Network. Multiple Myeloma Version 1.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf. Accessed November ~~11, 2024~~30, 2025.
~~8.~~9. Pillarisetti K, Powers G, Luistro L, et al. Teclistamab is an active T cell-redirecting bispecific antibody against B-cell maturation antigen for multiple myeloma. Blood Adv. 2020;4(18):4538-4549.
~~9.~~10. Usmani SZ, Garfall AL, van de Donk NWCJ, et al. Teclistamab, a B-cell maturation antigen × CD3 bispecific antibody, in patients with relapsed or refractory multiple myeloma (MajesTEC-1): a multicentre, open-label, single-arm, phase 1 study. Lancet. 2021;398(10301):665-674.

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
J9380	Injection, teclistamab-cqyv, 0.5 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Policy created	05.01.23	08.28.23
Added updated HCPCS code [J9380]	02.10.24	5.10.24
No significant changes; inactive HCPCS codes removed; references reviewed and updated.	11.21.24	01.27.25
Annual review: decreased serum M-protein criteria option from ≥ 1 g/dL to ≥ 0.5 g/dL for multiple myeloma criteria alignment; added	05.14.25	08.14.25

Reviews, Revisions, and Approvals	Date	LDH Approval Date
additional option to currently required measurable disease requirement to allow for progressive disease as defined by IMWG; removed exclusion for previous treatment with anti-BCMA targeted therapy; revised all Commercial approval durations to "6 months or to the member's renewal date, whichever is longer" per template for this injectable agent; references reviewed and updated.		
Annual review: revised initial approval duration to 12 months; added combination therapy option with Talvey for ≥ 3 prior lines of therapy per NCCN; for continued therapy, added dosing option for not exceeding 1.5 mg/kg every two weeks and if dose requested is 1.5 mg/kg per week, added requirement for documentation supporting member has not achieved and maintained a complete response or better for a minimum of 6 months per PI; references reviewed and updated	03.09.26	

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. LHCC 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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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.

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