

Field Name	Field Description
<b><u>Prior Authorization Group Description</u></b>	<b><u>Anti-CD19 CAR-T Immunotherapies</u></b>
<b><u>Drugs</u></b>	<b><u>Kymriah (tisagenlecleucel), Yescarta (axicabtagene ciloleucel), Tecartus (brexucabtagene autoleucel), Breyanzi (lisocabtagene maraleucel)</u></b>
<b><u>Covered Uses</u></b>	<b><u>Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.</u></b>
<b><u>Exclusion Criteria</u></b>	<b><u>Patients with primary central nervous system lymphoma</u></b>
<b><u>Required Medical Information</u></b>	<b><u>See “Other Criteria”</u></b>
<b><u>Age Restrictions</u></b>	<b><u>See “Other Criteria”</u></b>
<b><u>Prescriber Restrictions</u></b>	<b><u>Prescriber must be an oncologist, hematologist or other prescribers who specialize in the treatment of lymphoma.</u></b>
<b><u>Coverage Duration</u></b>	<b><u>If all the criteria are met, the initial request will be approved for a one – time infusion per lifetime.</u></b>
<b><u>Other Criteria</u></b>	<p data-bbox="570 999 1349 1073"><b><u>**Drug is being requested through the member’s medical benefit**</u></b></p> <p data-bbox="500 1073 789 1108"><b><u>Initial authorization:</u></b></p> <ul data-bbox="548 1108 1390 1476" style="list-style-type: none"> <li data-bbox="548 1108 1354 1182">• <b><u>Patient must not have received prior anti-CD19 CAR-T therapy.</u></b></li> <li data-bbox="548 1182 1304 1255">• <b><u>Patient will be screened for HBV, HCV, and HIV in accordance with clinical guidelines.</u></b></li> <li data-bbox="548 1255 1377 1329">• <b><u>Patient does not have an active infection or inflammatory disorder.</u></b></li> <li data-bbox="548 1329 1138 1360">• <b><u>Patient has a life expectancy &gt;12 weeks.</u></b></li> <li data-bbox="548 1360 1390 1476">• <b><u>Patient will not receive live virus vaccines for at least 6 weeks prior to the start of lymphodepleting chemotherapy and until immune recovery following treatment.</u></b></li> </ul> <p data-bbox="500 1514 639 1545"><b><u>Leukemia</u></b></p> <p data-bbox="500 1583 1273 1619"><b><u>B-cell precursor Acute Lymphoblastic Leukemia (ALL):</u></b></p> <ul data-bbox="548 1619 1390 1734" style="list-style-type: none"> <li data-bbox="548 1619 992 1654">• <b><u>If the request is for Kymriah</u></b> <ul data-bbox="646 1654 1390 1734" style="list-style-type: none"> <li data-bbox="646 1654 1187 1692">○ <b><u>Patient is 25 years of age or younger</u></b></li> <li data-bbox="646 1692 1390 1734">○ <b><u>ALL that is refractory or in second or later relapse</u></b></li> </ul> </li> </ul> <p data-bbox="500 1801 976 1837"><b><u>Non-Hodgkin’s Lymphoma (NHL)</u></b></p>

<p><u>Revision/Review</u> <u>Date: 6/2021</u></p>	<p><b><u>Mantle Cell Lymphoma (MCL):</u></b></p> <ul style="list-style-type: none"><li>• <b><u>If the request is for Tecartus:</u></b><ul style="list-style-type: none"><li>○ <b><u>Patient is 18 years of age or older</u></b></li><li>○ <b><u>Patient has relapsed/refractory disease defined as failure of BOTH the following lines of therapy:</u></b><ul style="list-style-type: none"><li>▪ <b><u>Chemoimmunotherapy such as an anti-CD20 monoclonal antibody (e.g. Rituxan) + any chemotherapeutic agent</u></b></li><li>▪ <b><u>Bruton Tyrosine Kinase (BTK) Inhibitor (e.g. Calquence, Imbruvica, Brukinsa)</u></b></li></ul></li></ul></li></ul> <p><b><u>Other forms of NHL:</u></b></p> <ul style="list-style-type: none"><li>• <b><u>If the request is for Brevanzi (lisocabtagene maraleucel), Kymriah (tisagenlecleucel), Yescarta (axicabtagene ciloleucel)</u></b><ul style="list-style-type: none"><li>○ <b><u>Use is supported by a labeled indication or NCCN guidelines</u></b></li><li>○ <b><u>Patient is 18 years of age or older</u></b></li><li>○ <b><u>Patient has relapsed/refractory disease defined as failure of two or more lines of systemic therapy</u></b></li></ul></li></ul> <p><b><u>Re-authorization:</u></b></p> <ul style="list-style-type: none"><li>• <b><u>Treatment exceeding 1 dose per lifetime will not be authorized.</u></b></li></ul> <p><b><u>Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.</u></b></p>
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