# Molina Clinical Policy
# Breyanzi™ (lisocabtagene maraleucel)
# Policy Number: 400

**Last Approval: 8/09/2023**
**Next Review Due By: August 2024**

## POLICY SECTIONS



## DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

## POLICY DESCRIPTION

To define and describe the accepted indications for Breyanzi (lisocabtagene maraleucel) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

## INDICATIONS and/or LIMITATIONS OF COVERAGE

**A. Continuation requests for a not-approvable medication shall be exempt from this policy provided:**

1. The requested medication was used within the last year, **AND**
2. The member has not experienced disease progression and/or no intolerance to the requested medication, **AND**
3. Additional medication(s) are not being added to the continuation request.

**B. Diffuse Large B-Cell Lymphoma (DLBCL), confirmed CD-19 positive [Lymphoma sub-types include 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]**

1. Breyanzi (lisocabtagene maraleucel) may be used for the treatment of adult members with relapsed or refractory diffuse large B-cell lymphoma and the above sub-types, confirmed documentation of CD-19 positive disease, **AND** who have the following:
   a. Refractory disease to first line chemoimmunotherapy or relapse within 12 months of first line chemoimmunotherapy **OR**
   b. Relapse after first line chemoimmunotherapy AND are not eligible for hematopoietic stem cell transplantation (HSCT) **OR**

c. For chemotherapy-refractory disease after 2 or more lines of systemic chemotherapy.

## EXCLUSION CRITERIA

A. Disease progression during or after taking Breyanzi (lisocabtagene maraleucel) or another anti-CD19 CAR-T cell therapy [e.g., Kymriah (tisagenlecleucel) or Yescarta (axicabtagene ciloleucel)].

B. Lack of confirmed documentation of CD-19 positivity in tumor cells.

C. Treatment with Breyanzi (lisocabtagene maraleucel) exceeds the maximum limit of 110 X $10^6$ CAR-positive viable T-cells.

D. Treatment exceeds the maximum duration limit as one time administration.

E. The member does not have adequate bone marrow reserve.

F. The member does not have adequate renal, hepatic, cardiac and pulmonary function defined as:
   a. Creatinine clearance > 30 mL/min
   b. Serum ALT ≤ 5 times the upper limit of normal
   c. Cardiac ejection fraction ≥ 40%, no evidence of pericardial effusion as determined by an echocardiogram (ECHO), and no clinically significant pleural effusion.

G. Investigational use of Breyanzi (lisocabtagene maraleucel) with an off-label indication that is not sufficient in evidence or is not generally accepted by the medical community. Sufficient evidence that is not supported by CMS recognized compendia or acceptable peer reviewed literature is defined as any of the following:

   a. Whether the clinical characteristics of the patient and the cancer are adequately represented in the published evidence.

   b. Whether the administered chemotherapy/biologic therapy/immune therapy/targeted therapy/other oncologic therapy regimen is adequately represented in the published evidence.

   c. Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients. Generally, the definition of Clinically Meaningful outcomes are those recommended by ASCO, e.g., Hazard Ratio of < 0.80 and the recommended survival benefit for OS and PFS should be at least 3 months.

   d. Whether the experimental design, considering the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover).

   e. That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs.

   f. That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.

   g. That abstracts (including meeting abstracts) without the full article from the approved peer-reviewed journals lack supporting clinical evidence for determining accepted uses of drugs.

## MEDICATION MANAGEMENT

A. Please refer to the FDA label/package insert for details regarding these topics.

## APPLICABLE CPT / HCPCS PROCEDURE CODES

**CPT (Current Procedural Terminology) Codes**

| CPT | Description |
|---|---|
| **0537T** | Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day |
| **0538T** | Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (e.g., cryopreservation, storage) |
| **0539T** | Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration |
| **0540T** | Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous |

**HCPCS (Healthcare Common Procedure Coding System) Code**

| HCPCS | Description |
|---|---|
| **Q2054** | Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose |

**AVAILABLE DOSAGE FORMS:** Breyanzi is supplied in vials as separate frozen suspensions of each CD8 and CD4 component; each component is packed in a carton containing up to 4 vials, depending upon the concentration of the cryopreserved drug product CAR-positive vial T cells.

**CODING DISCLAIMER.** Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

## APPROVAL HISTORY

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|---|---|
| **8/09/2023** | Changes to indications/inclusion criteria to remove reference to preferred drug listing, and additional qualifications in section B for Diffuse Large B-Cell Lymphoma. Exclusion criteria revised to add section B and removed a few criteria. Updated code descriptions for codes 0537T, 0538T, 0539T, and 0540T. Reviewed by board certified Oncologist. |
| **8/10/2022** | Adopted NCH policy and retired MCP. |

## REFERENCES

A. Kamdar M, et al. TRANSFORM Clinical Trial. Lisocabtagene maraleucel versus standard of care with salvage chemotherapy followed by autologous stem cell transplantation as second-line treatment in patients with relapsed or refractory large B-cell lymphoma (TRANSFORM): results from an interim analysis of an open-label, randomised, phase 3 trial. Lancet. 2022 Jun 18;399(10343):2294-2308.
B. Abramson JS, et al. Lisocabtagene maraleucel for patients with relapsed or refractory large B-cell lymphomas (TRANSCEND NHL 001): a multicentre seamless design study. Lancet. 2020 Sep 19;396(10254):839-852.
C. Breyanzi prescribing information. Juno Therapeutics, Inc. Bothell, WA 2022.
D. Ellis LM, et al. American Society of Clinical Oncology perspective: Raising the bar for clinical trials by defining clinically meaningful outcomes. J Clin Oncol. 2014 Apr 20;32(12):1277-80.
E. Medicare Benefit Policy Manual Chapter 15 Covered Medical and Other Health Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.
F. NCQA UM 2023 Standards and Elements.

## APPENDIX

***Reserved for State specific information.*** *Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.*