CarePartners of Connecticut MEDICARE ADVANTAGE

Medical Necessity Guidelines

Medical Benefit Drugs

Breyanzi® (lisocabtagene maraleucel)

Effective: September 1, 2025

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	Yes ☒ No ☐

Applies to:

☒ CarePartners of Connecticut Medicare Advantage HMO plans, Fax 617-673-0956

☒ CarePartners of Connecticut Medicare Advantage PPO plans, Fax 617-673-0956

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Chimeric antigen receptor T-cell therapy (CAR T-cell therapy), a type of immunotherapy which may also be referred to as adoptive T-cell therapy, attempts to program patients' own immune systems to recognize and attack cancer cells. The first step in this therapy is to remove T-cells from the patient via apheresis, a process that removes blood from the body and removes one or more blood components (such as white blood cells, plasma, or platelets). The remaining blood is then returned to the body. The T-cells are then sent to a drug manufacturing facility or laboratory where they are genetically engineered to produce chimeric antigen receptors (CARs) on their surface. These CARs are what allow the T-cells to recognize an antigen on targeted tumor cells. The genetically modified T-cells are grown in the lab until there are enough of them (many millions) to freeze and return to the center treating the patient. There they are infused into the recipient with the expectation that the CAR T-cells will recognize and kill cancerous cells that have the targeted antigen on their surface. Since the CAR T-cells may remain in the body long after the infusion, it is possible the treatment can bring about long-term remission. CAR T-cell therapy can be used to treat certain hematologic malignancies when the disease is relapsed or refractory to standard line(s) of treatment.

Food and Drug Administration (FDA) Approved Indications:

BREYANZI (lisocabtagene maraleucel) is a CD19-directed genetically modified autologous T cell immunotherapy indicated for the treatment of:

- Adult patients with large B-cell lymphoma (LBCL), 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, who have:
    - Refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy
    - Refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplantation (HSCT) due to comorbidities or age.
    - Relapsed or refractory disease after two or more lines of systemic therapy
- Adult patients with relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) who have:
    - Received at least 2 prior lines of therapy including a Bruton tyrosine kinase (BTK) inhibitor and a B-cell lymphoma 2 (BCL-2) inhibitor.
- Adult patients with relapsed or refractory mantle cell lymphoma (MCL) who have received at least 2 prior lines of systemic therapy, including a Bruton tyrosine kinase (BTK) inhibitor.

Limitations of Use: Breyanzi is not indicated for the treatment of patients with primary central nervous system lymphoma.

- **NOTE**: According to recent updated guidance from the FDA, the REMS Program requirement is no longer required.[1]
- **NOTE**: Tocilizumab must be available to treat potential serious adverse reactions as needed.

Care Partners of Connecticut uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Medicare Advantage plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals are the basis for coverage determinations where available. For Care Partners of Connecticut members, the following criteria is used: Chimeric Antigen Receptor (CAR) T- cell Therapy NCD 110.24

Clinical Guideline Coverage Criteria

The Plan may cover Breyanzi for Members, when **all** the following criteria are met:

For Large B-cell lymphoma

1. The Member is 18 years of age or older and has been diagnosed with large B-cell lymphoma (LBCL), 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.

AND

2. Who have **one** of the following:
    a. Refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy.
    b. Refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplantation (HSCT) due to comorbidities or age.
    c. Relapsed or refractory disease after two or more lines of systemic therapy.

AND

3. The Member does not have primary central nervous system (CNS) lymphoma.

*Relapsed/Refractory defined as disease progression after the last treatment regimen or refractory/suboptimal response to the most recent therapy.

For Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic lymphoma (SLL)

1. The Member is 18 years of age or older and has been diagnosed with relapsed or refractory chronic lymphocytic leukemia (CLL) or Small Lymphocytic lymphoma (SLL).

AND

2. The Member has received two prior lines of therapy including a Burton tyrosine kinase (BTK) inhibitor (e.g., acalabrutinib, ibrutinib, zanubrutinib) and a B-cell lymphoma 2 (BCL-2) inhibitor (e.g., venetoclax).

NOTE: Documentation submitted must list previous lines of treatment/systemic therapies and date of each therapy.

For Mantle Cell Lymphoma

1. The Member is 18 years of age or older and has been diagnosed with relapsed or refractory MCL.

AND

2. The Member has received two or more lines of systemic therapy including a Burton tyrosine kinase (BTK) inhibitor (e.g., acalabrutinib, ibrutinib, zanubrutinib).

AND

3. The Member has an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 1.

In addition to the above criteria, the Plan may cover Breyanzi in an outpatient setting when the provider attests that they have assessed the Member and determined that outpatient administration is clinically appropriate.

NOTE: Prior authorization for Breyanzi is required regardless of hospital inpatient or outpatient setting.

ECOG Performance Status:

- 0: Fully active, no restrictions on activities. A performance status of 0 means no restrictions in the sense that someone is able to do *everything* they were able to do prior to their diagnosis.
- 1: Unable to do strenuous activities, but able to carry out light housework and sedentary activities. This status basically means you can't do heavy work but can do anything else.
- 2: Able to walk and manage self-care, but unable to work. Out of bed more than 50% of waking hours. In this category, people are usually unable to carry on any work activities, including light office work.
- 3: Confined to bed or a chair more than 50 percent of waking hours. Capable of limited self-care.
- 4: Completely disabled. Totally confined to a bed or chair. Unable to do any self-care.
- 5: Death

Limitations

- Members who have had prior treatment with any form of CAR T-cell therapy, including therapies in clinical trial settings, will not be approved for additional CAR-T therapy.

- Authorization for Breyanzi is limited to a one-time infusion.
- All other indications other than those listed above are considered experimental/investigational and not medically necessary.

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-CD19 CAR-positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic doses

References:

1. FDA Eliminates Risk Evaluation and Mitigation Strategies (REMS) for Autologous Chimeric Antigen Receptor (CAR) T cell Immunotherapies. https://www.fda.gov/vaccines-blood-biologics/safety-availability-biologics/fda-eliminates-risk-evaluation-and-mitigation-strategies-rems-autologous-chimeric-antigen-receptor. Published June 26, 2025. Accessed June 26, 2025.
2. Hayes, Inc. Medical Technology Directory Report. Adoptive Immunotherapy Using Genetically Modified Lymphocytes for Lymphoproliferative Disorders and Hematological Malignancies. September 7, 2017. Available at hayesinc.com. Last accessed October 26, 2017.
3. United States Department of Health and Human Services, National Institutes of Health, National Cancer Institute. CAR-T Cells: Engineering Patients' Immune Cells to Treat Their Cancers. Available at cancer.gov. Last accessed October 24, 2017.
4. Leukemia & Lymphoma Society. Chimeric Antigen Receptor (CAR) T-Cell Therapy Facts. Available at lls.org. Last accessed October 20, 2017.
5. Wang M, Munoz J, Goy A, et al. KTE-X19 CAR T-Cell Therapy in Relapsed or Refractory Mantle-Cell Lymphoma. N Engl J Med. 2020;382(14):1331-1342. doi:10.1056/NEJMoa1914347.
6. Initial treatment of mantle cell lymphoma. UpToDate.com/login [via subscription only]. Accessed: July 30, 2020.
7. United States Food and Drug Administration. Package Insert-BREYZANI. Available at fda.gov. February 2021.
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13. Center for Medicare and Medicaid National Coverage Determination (NCD) for Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24). https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=374&ncdver=1&DocID=110.24&bc=gAAAAAIAAAAA&.
14. Hansen, D. K., Liu, Y. H., Ranjan, S., Bhandari, H., Potluri, R., McFarland, L., De Braganca, K. C., & Huo, S. (2023). The Impact of Outpatient versus Inpatient Administration of CAR-T Therapies on Clinical, Economic, and Humanistic Outcomes in Patients with Hematological Cancer: A Systematic Literature Review. *Cancers*, *15*(24), 5746. https://doi.org/10.3390/cancers15245746
15. Siddiqi T, Maloney DG, Kenderian SS, et al. Lisocabtagene maraleucel in chronic lymphocytic leukaemia and small lymphocytic lymphoma (TRANSCEND CLL 004): a multicentre, open-label, single-arm, phase 1-2 study. Lancet. 2023;402(10402):641-654. doi:10.1016/S0140-6736(23)01052-8
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22. Nastoupil LJ, Bonner A, Wang P, et al. Matching-adjusted indirect comparison of efficacy and safety of lisocabtagene maraleucel and mosunetuzumab for the treatment of third-line or later relapsed or refractory follicular lymphoma. Exp Hematol Oncol. 2025;14(1):30. Published 2025 Mar 5. doi:10.1186/s40164-025-00610-1

Approval And Revision History

September 21, 2022: Reviewed by the Medical Policy Approval Committee (MPAC)

Subsequent endorsement date(s) and changes made:

- Originally approved at September 21, 2022 MPAC effective January 1, 2023
- Administrative update: November 2023 added Medical Benefit Drugs to title, updated CPCT logo, and clarified NCD language effective January 1, 2024
- October 18, 2023: Reviewed by MPAC, renewed without changes effective January 1, 2024
- December 1, 2023: Reviewed by the Joint Medical Policy and Health care Services Utilization Management Committee effective January 1, 2024.
- January 2024: added criteria for allow for outpatient administration and updated references effective March 1, 2024
- April 19, 2024: criteria updates reviewed and approved by the Joint Medical Policy and Health care Services Utilization Management Committee
- April 17, 2024: Reviewed at Medical Policy Approval Committee Added Indication for relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) effective June 1, 2024.
- July 22, 2024: Reviewed by MPAC added Mantle Cell Lymphoma indication and opened up to all Follicular Lymphoma, not just Follicular Lymphoma grade 3B, effective September 1, 2024. Added ECOG Table.
- November 21, 2024: Reviewed by MPAC, renewed without changes. Effective January 1, 2025.
- December 13, 2024: Reviewed by UM Committee; Coding updated: Removal of prior authorization from 0537T, 0538T, 0539T, and 0540T. Effective January 1, 2025.
- December 18, 2024: Reviewed by MPAC; Coding updated: Removal of prior authorization from 0537T, 0538T, 0539T, and 0540T. Effective January 1, 2025
- February 19, 2025: Reviewed by MPAC. Removed Richter's transformation limitation. References updated. Effective April 1, 2025.
- June 18, 2025: Reviewed by MPAC. Annual review.
- July 16, 2025: Reviewed by MPAC. REMS language removed from both the Overview and Criteria sections. Two notes were added in the Overview section. References updated. Effective date September 1, 2025.

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment, or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.