

Effective March 1, 2024

<b>Prior Authorization Required</b> If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
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#### 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 CART cells may remain in the body long after the infusion, it is possible the treatment can bring about long-term remission. CART 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 grade 3B, 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

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

**REMS Program:** Because of the serious risks of CRS and neurologic toxicities, BREYANZI is available only under a restricted program called BREYANZI REMS (Risk Evaluation Mitigation Strategy). The goals of BREYANZI REMS are to mitigate the risks of CRS and neurologic toxicities by:

- Ensuring that hospitals and associated clinics that dispense BREYANZI are specially certified and have on-site immediate access to tocilizumab.
- Ensuring that those who prescribe, dispense, or administer BREYANZI are aware of how to manage the risks of CRS and neurologic toxicities.

For more information about the BREYANZI REMS program, call 1-888-423-5436 or go to <https://www.breyanzirems.com/>.

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:

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 grade 3B

**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

**AND**

4. The treating facility is certified under the Risk Evaluation and Mitigation Strategy (REMS) System program for Breyanzi.

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

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

In addition to the above criteria, the Plan may cover Breyanzi in an outpatient setting when all of the following criteria is met:

1. The provider attests that they have assessed the Member and determined that outpatient administration is clinically appropriate.
2. The provider attests that the Member meets and understands the requirements of safety and monitoring post infusion as described by the Breyanzi REMS program.

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

## 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

**Table 2: CPT Codes**

CPT Codes	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

CPT Codes	Description
0540T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous

## References:

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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.
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7. United States Food and Drug Administration. Package Insert-BREYZANI. Available at fda.gov. February 2021.
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12. Shah BD, Ghobadi A, Oluwole OO, et al. KTE-X19 for relapsed or refractory adult B-cell acute lymphoblastic leukemia: phase 2 results of the single-arm, open-label, multicenter ZUMA-3 study. *Lancet*. 2021;398(10299):491-502. doi:10.1016/S0140-6736(21)01222-8
13. Breyanzi [package insert]. Bothell, WA: Juno Therapeutics Inc.; June 2022.
14. 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=gAAAAIAAAAA&>.
15. 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>

## 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
- January 17, 2024: Reviewed by MPAC, added criteria for allow for outpatient administration and updated references effective March 1, 2024

## 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.