CarePartners of Connecticut MEDICARE ADVANTAGE

Medical Necessity Guidelines
Medical Benefit Drugs

Tecartus® (brexucabtagene autoleucel)

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:

TECARTUS (brexucabtagene autoleucel) is a CD19-directed genetically modified autologous T cell immunotherapy indicated for the treatment of:

- Adult patients with relapsed or refractory mantle cell lymphoma (MCL). This indication is approved under accelerated approval based on overall response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.
- Adult patients with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL)
- **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 Tecartus for Members, when **all** the following clinical criteria are met:

1. The Member meets **ONE (1)** of the following criteria:
   a. The Member is diagnosed with relapsed* or refractory* mantle cell lymphoma (MCL), ***or***
   b. The Member is diagnosed with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL)

   AND
2. The Member is 18 years of age or older.

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

In addition to the above criteria, the Plan may cover Tecartus 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 Tecartus is required regardless of hospital inpatient or outpatient setting.

Limitations

- Tecartus is limited to a one-time infusion.
- 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-cell therapy.
  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
Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti-CD19 CAR positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic dose

Table 2: CPT Codes

CPT Codes	Description
none	

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. Center for Medicare and Medicaid National Coverage Determination (NCD) for Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) last accessed January 25, 2022 at cms.gov/medicarecoveragedatabase/details/ncddetails.aspx?ncdid=374&ncdver=1&bc=CAAAAAAAAAAA.
3. Decision memo for chimeric antigen receptor (CAR) T-cell therapy for cancers (CAG-00451N). Centers for Medicare & Medicaid Services (CMS). August 2019. https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=291.
4. FDA Approves First Cell-Based Gene Therapy for Adult Patients with Relapsed or Refractory MCL. U.S. Food and Drug Administration. https://www.fda.gov/news-events/press-announcements/fda-approves-first-cellbased-gene-therapy-adult-patients-relapsed-or-refractory-mcl Published 2020. Accessed November 2, 2021.
5. Tecartus [package insert]. Los Angeles, CA: Kite Pharma; October 2021. Accessed online June 2, 2022 at https://www.gilead.com/-/media/files/pdfs/medicines/oncology/tecartus/tecartus-pi.pdf.
6. 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
- 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.
- June 18, 2025: Reviewed by MPAC. Annual review.
- July 16, 2025: Reviewed by MPAC. REMS language removed from both Overview and Criteria sections. Two notes were added in the Overview section. References were updated. Effective 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.