# Clinical Policy: Lisocabtagene Maraleucel (Breyanzi)

Reference Number: CP.PHAR.483
Effective Date: 02.05.21
Last Review Date: 08.21
Line of Business: Commercial, HIM, Medicaid Revision Log

**See Important Reminder at the end of this policy for important regulatory and legal information.**

**Description**
Lisocabtagene maraleucel (Breyanzi®) is a CD19-directed genetically modified autologous T-cell immunotherapy.

**FDA Approved Indication(s)**
Breyanzi is indicated for the treatment of adult patients with relapsed or refractory large B-cell lymphoma (LBCL) after two or more lines of systemic therapy, 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.

Limitation of use: Breyanzi is not indicated for the treatment of patients with primary central nervous system (CNS) lymphoma.

**Policy/Criteria**
*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

All requests reviewed under this policy **require medical director review.**

It is the policy of health plans affiliated with Centene Corporation® that Breyanzi is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. Large B-Cell Lymphoma*** (must meet all)**:**

**Only for initial treatment dose; subsequent doses will not be covered.*

1. Diagnosis of one of the following LBCL (a–f );
   a. DLBCL;
   b. DLBCL transformed from one of the following (i – v):
      i. Follicular lymphoma;
      ii. Nodal marginal zone lymphoma;
      iii. Gastric mucosa-associated lymphoid tissue (MALT) Lymphoma;
      iv. Nongastric MALT Lymphoma (noncutaneous);
      v. Splenic marginal zone lymphoma
   c. Primary mediastinal large B-cell lymphoma;
   d. High-grade B-cell lymphomas with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma) or high-grade B-cell lymphomas, not otherwise specified;

e. Monomorphic post-transplant lymphoproliferative disorders (B-cell type);
f. AIDS-related primary effusion lymphoma;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Disease is refractory or member has relapsed after ≥ 2 lines of systemic therapy that includes an anti-CD20 therapy (e.g., rituximab) and one anthracycline-containing regimen (e.g., doxorubicin);*
**Prior authorization may be required for rituximab*
5. Member does not have primary CNS disease;
6. Member has not previously received treatment with CAR T-cell immunotherapy (e.g., Kymriah™, Yescarta™);
7. Breyanzi is not prescribed concurrently with other CAR T-cell immunotherapy (e.g., Kymriah, Yescarta);
8. Dose does not exceed 110 x $10^6$ chimeric antigen receptor (CAR)-positive viable T cells.

**Approval duration: 3 months *(1 dose only, with 4 doses of tocilizumab (Actemra) if requested at up to 800 mg per dose)***

**B. Other diagnoses/indications**
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

## II. Continued Therapy

**A. Large B-Cell Lymphoma**
1. Continued therapy will not be authorized as Breyanzi is indicated to be dosed one time only.

**Approval duration: Not applicable**

**B. Other diagnoses/indications**
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

## III. Diagnoses/Indications for which coverage is NOT authorized:

**A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents;
**B.** Primary CNS disease.

## IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

ALC: absolute lymphocyte count
CAR: chimeric antigen receptor

CNS: central nervous system
CRS: cytokine release syndrome
DLBCL: diffuse large B-cell lymphoma
FDA: Food and Drug Administration
LBCL: large B-cell lymphoma
MALT: mucosa-associated lymphoid tissue

*Appendix B: Therapeutic Alternatives*
*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| **First-Line Treatment Regimens** | | |
| RCHOP (Rituxan® (rituximab), cyclophosphamide, doxorubicin, vincristine, prednisone) | Varies | Varies |
| RCEPP (Rituxan® (rituximab), cyclophosphamide, etoposide, prednisone, procarbazine) | Varies | Varies |
| RCDOP (Rituxan® (rituximab), cyclophosphamide, liposomal doxorubicin, vincristine, prednisone) | Varies | Varies |
| DA-EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicine) + Rituxan® (rituximab) | Varies | Varies |
| RCEOP (Rituxan® (rituximab), cyclophosphamide, etoposide, vincristine, prednisone) | Varies | Varies |
| RGCVP (Rituxan®, gemcitabine, cyclophosphamide, vincristine, prednisone) | Varies | Varies |
| **Second-Line Treatment Regimens** | | |
| Bendeka® (bendamustine) ± Rituxan® (rituximab) | Varies | Varies |
| CEPP (cyclophosphamide, etoposide, prednisone, procarbazine) ± Rituxan® (rituximab) | Varies | Varies |
| CEOP (cyclophosphamide, etoposide, vincristine, prednisone) ± Rituxan® (rituximab) | Varies | Varies |
| DA-EPOCH ± Rituxan® (rituximab) | Varies | Varies |
| GDP (gemcitabine, dexamethasone, cisplatin) ± Rituxan® (rituximab) | Varies | Varies |
| gemcitabine, dexamethasone, carboplatin ± Rituxan® (rituximab) | Varies | Varies |
| GemOx (gemcitabine, oxaliplatin) ± Rituxan® (rituximab) | Varies | Varies |
| gemcitabine, vinorelbine ± Rituxan® (rituximab) | Varies | Varies |
| lenalidomide ± Rituxan® (rituximab) | Varies | Varies |
| Rituxan® (rituximab) | Varies | Varies |
| DHAP (dexamethasone, cisplatin, cytarabine) ± Rituxan® (rituximab) | Varies | Varies |
| DHAX (dexamethasone, cytarabine, oxaliplatin) ± Rituxan® (rituximab) | Varies | Varies |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| ESHAP (etoposide, methylprednisolone, cytarabine, cisplatin) ± Rituxan® (rituximab) | Varies | Varies |
| ICE (ifosfamide, carboplatin, etoposide) ± Rituxan® (rituximab) | Varies | Varies |
| MINE (mesna, ifosfamide, mitoxantrone, etoposide) ± Rituxan® (rituximab) | Varies | Varies |

*Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.*

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): none reported
- Boxed warning(s): cytokine release syndrome and neurologic toxicities

*Appendix D: General Information*

- Patients with primary CNS disease were excluded from the TRANSCEND NHL 001 trial. For primary CNS lymphoma, NCCN treatment guidelines for CNS cancers recommend a high-dose methotrexate induction based regimen or whole brain radiation therapy, and consolidation therapy with high-dose chemotherapy with stem cell rescue, high-dose cytarabine with or without etoposide, low dose whole brain radiation therapy, or continuation with monthly high-dose methotrexate-based regimen.
- In the TRANSCEND NHL 001 trial, three of six patients in the efficacy-evaluable set with secondary CNS lymphoma achieved a complete response.
- No prespecified threshold for blood counts, including absolute lymphocyte count, was required for enrollment in the TRANSCEND NHL 001 trial.

## V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| LBCL | Target dose: 50 to 110 x $10^6$ CAR-positive viable T cells | 110 x $10^6$ CAR-positive viable T cells |

## VI. Product Availability

Single-dose 5 mL vial: frozen suspension of genetically modified autologous T-cells labeled for the specific recipient

## VII. References

1. Breyanzi Prescribing Information. Bothell, WA: Juno Therapeutics, Inc.; February 2021. Available at: https://packageinserts.bms.com/pi/pi_breyanzi.pdf. Accessed February 8, 2021.
2. ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). Identifier NCT02631044, Study Evaluating the Safety and Pharmacokinetics of JCAR017 in B-cell Non-Hodgkin Lymphoma (TRANSCEND-NHL-001); 23 December 2019. Available at: https://clinicaltrials.gov/ct2/show/NCT02631044?term=lisocabtagene&draw=2&rank=4. Accessed March 24, 2020.

3. Abramson JS, Palomba ML, Gordon LI, et al. Lisocabtagene maraleucel for patients with relapsed or refractory large B-cell lymphomas (TRANSCEND NHL 001): a multicentre seamless design study. Lancet. 2020 September 19; 396: 839-852.
4. National Comprehensive Cancer Network. B-cell Lymphomas Version 2.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed February 16, 2021.
5. National Comprehensive Cancer Network Drug and Biologics Compendium. Available at http://www.nccn.org/professionals/drug_compendium. Accessed February 16, 2021.
6. National Comprehensive Cancer Network. Central Nervous System Cancers Version 3.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf. Accessed February 16, 2021.

**Coding Implications**
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| HCPCS Codes | Description |
|---|---|
| TBD | Lisocabtagene Maraleucel, Autologous Anti-CD19 CAR T Cells, Including Leukapheresis And Dose Preparation Procedures, Per Infusion |

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| Policy created pre-emptively. | 03.31.20 | 05.20 |
| Drug is now FDA approved – criteria updated per FDA labeling; removed minimum absolute lymphocyte count requirement; updated reference for HIM off-label use to HIM.PA.154 (replaces HIM.PHAR.21); references reviewed and updated; Added disclaimer under Policy/Criteria "All requests reviewed under this policy require medical director review." | 02.08.21 | 05.21 |
| Clarified per NCCN Compendium additional DLBCL transformed diseases; added supported use for AIDS-related primary effusion lymphoma. | 05.27.21 | 08.21 |

**Important Reminder**
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.