MetroPlus Health

Policy and Procedure

Title: Kymriah	**Division: Medical Management** **Department: Utilization Management**
Approval Date: 3/30/2018	**LOB: Medicaid, FHP, HIV SNP, CHP, MetroPlus Gold, Market Plus, Essential, HARP**
Effective Date: 3/30/2018	**Policy Number: UM-MP219**
Review Date: 4/25/2023	**Cross Reference Number:**
Retired Date:	**Page 1 of 5**

1. POLICY DESCRIPTION:

Medical Oncology- Anti- CD19 CAR-T Immunotherapy, Kymriah (Tisagenlecleucel)

2. RESPONSIBLE PARTIES:

Medical Management Administration, Utilization Management, Integrated CareManagement, Pharmacy, Claims Department, Provider Contracting.

3. DEFINITIONS:

Kymriah (Tisagenlecleucel) is a chimeric antigen receptor T Cell (CAR-T) which reprograms a patient's own T cells to identify and eliminate CD19 expressing malignant and normal cells. Upon binding to CD-19 expressing cells, the CAR promotes T-cell expansion, activation and target cell elimination.

Kymriah is indicated for the treatment of:

- Patients up to 25 years of age with B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse.

- Adult patients with relapsed or refractory (r/r) large B-cell lymphoma after two or morelines of systemic therapy including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, high grade B-cell lymphoma and DLBCL arising from follicular lymphoma.

- Adult patients with relapsed or refractory follicular lymphoma (FL) after two or more lines of systemic therapy. (This indication is approved under accelerated approval based on response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.)

All other uses for Kymriah are considered experimental and investigational.

4. POLICY:

Kymriah will be considered medically necessary when the following conditions of coverage have been met:

Initial Request:

B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second orlater relapse.

a. Member is 3-25 years of age
b. Member is diagnosed with refractory or relapsed B-cell precursor acute lymphoblastic leukemia (ALL). The disease is refractory or in second or later relapse defined as one of the following:
    i. Second or later bone marrow relapse
    ii. Any bone marrow relapse after allogenic stem cell transplantation (SCT),and must be 6 months or more from SCT at the time of CAR-T cell immunotherapy infusion
    iii. Failure of 2 cycles of a standard chemotherapy regimen or chemo refractory as defined by not achieving a complete remission (CR)after 1 standard chemotherapy for relapsed leukemia
    iv. Failure of 2 lines of tyrosine kinase inhibitor therapy (TKI) for patients with Philadelphia chromosome positive disease, or TKI is intolerant or contraindicated.
    v. Ineligible for allogeneic SCT
c. Member has not previously been treated with CAR-T therapy, including Kymirah.
d. Member has documentation of CD19 positive disease
e. Performance score on Karnofsky or Lansky Scale is greater than or equal to 50%.
f. Member has a documented life expectancy > 12 weeks
g. FDA approved dosing is administered
    - 50 kg or less: administer 0.2 to 5.0 x 106 CAR-positive viable T cells per kg body weight
    - above 50 kg: administer 0.1 to 2.5 x 108 CAR-positive viable T cells
h. Member does not have an active infection or inflammatory disorder
i. Member is screened for HBV, HCV, and HIV in accordance with clinical guidelines prior to collection of cells for manufacturing.
j. Healthcare facility/provider has enrolled in the Kymriah REMS and has training on the management of cytokine release syndrome (CRS) and neurological toxicities

Relapsed or refractory B-cell lymphoma

a. Member has been diagnosed with relapsed/refractory B-cell lymphoma including anyof the following:
    - Diffuse large B-cell lymphoma (DLBCL) not otherwise specified; OR
    - High grade B-cell lymphoma; OR

- Diffuse large B-cell lymphoma (DLBCL) arising from follicular lymphoma;

b. Member is 18 years of age or older
c. Member has experienced disease progression following a trial of two or more lines ofsystemic therapy; which include anthracycline chemotherapy agent and an anti-CD20antibody
d. Member has documentation of CD19 positive disease
e. Member does not have primary central nervous system lymphoma
f. Member does not have human immunodeficiency virus (HIV), active Hepatitis B or C, active uncontrolled infection and any autoimmune disease requiring immune suppression.
g. Member has not previously been treated with CAR-T therapy, including Kymirah.
h. FDA approved dosing is administered
    - A single-dose for infusion of 0.6 to 6.0 x 108 CAR-positive viable T cells
i. Healthcare facility/provider has enrolled in the Kymriah REMS and has training on the management of cytokine release syndrome (CRS) and neurological toxicities

Relapsed or refractory follicular lymphoma (FL)

a. Member has been diagnosed with relapsed or refractory follicular lymphoma (Grade 1, 2, 3a)
b. Member has experienced disease progression following a trial of two or more lines of systemic therapy; which include anthracycline chemotherapy agent and an anti-CD20 antibody
c. Member is 18 years of age or older
d. Member has not previously been treated with CAR-T therapy, including Kymirah
e. Member does not have an active infection or inflammatory disorder
f. Member is screened for HBV, HCV, and HIV in accordance with clinical guidelines prior to collection of cells for manufacturing.
g. FDA approved dosing is administered
    - A single-dose for infusion of 0.6 to 6.0 x 108 CAR-positive viable T cells
h. Healthcare facility/provider has enrolled in the Kymriah REMS and has training on the management of cytokine release syndrome (CRS) and neurological toxicities

Renewal Request

Repeat administration of Kymriah is investigational and will not be covered.

5. LIMITATIONS/EXCLUSONS

Kymriah is not indicated for the treatment of patients with primary central nervous system lymphoma.

6. APPLICABLE PROCEDURE CODES:

CPT Code	Description
Q2042	Tisagenlecleucel, up to 600 million CAR-positive viable T cells, including leukapheresis and dose preparation procedure, per infusion

7. APPLICABLE DIAGNOSIS CODES:

ICD Code	Description
C83.30 - C83.39	Diffuse large B-cell lymphoma
C91.00 - C91.02	Acute lymphoblastic leukemia

References

1. Kymriah [Product Information], Novartis Pharmaceuticals Corporation, East Hanover, NJ; August 2017. Available at:https://www.fda.gov/downloads/BiologicsBloodVaccines/CellularGeneTherapyProducts/ApprovedProducts/ UCM573941.pdf.
2. Porter DL, Hwang WT, Frey NV, et al. Chimeric antigen receptor T cells persist and induce sustained remissionsin relapsed refractory chronic lymphocytic leukemia. Sci Transl Med. 2015 Sep 2;7(303):303ra139. doi: 10.1126/scitranslmed.aac5415
3. ClinicalTrials.gov. Identifier NCT02228096. Study of Efficacy and Safety of CTL019 in Pediatric ALL Patients.Available at https://clinicaltrials.gov/ct2/show/NCT02228096?term=tisagenlecleucel&rank=1.
4. The Leukemia & Lymphoma Society (LLS). Ph-Positive ALL Therapy. Available at https://www.lls.org/leukemia/acute-lymphoblastic-leukemia/treatment/ph-positive-all-therapy
5. Kymriah [Product Information], Novartis Pharmaceuticals Corporation, East Hanover, NJ; May 2022.

6. IPD Analytics Client Log In - Pharma Market Insights. secure.ipdanalytics.com. Accessed April 17, 2023. https://secure.ipdanalytics.com/User/Pharma/RxStrategy/Page/389b4581-4323-4e36-b9df-9305d9bb0f7b#section-group-410419

REVISION LOG:

REVISIONS	DATE
Creation date	3/30/2018
Annual Review	3/15/2019
CPT Code Change	6/21/2019
Annual Review	6/23/2020
Pharmacy update	10/29/2020
Annual Review	4/30/2021
Annual Review	4/30/2022
Annual Review and Update	4/25/2023

Approved: Glendon Henry Digitally signed by Glendon Henry Date: 2023.04.26 07:41:58 -04'00' **Date:**	**Approved:** Sanjiv Shah MD Digitally signed by Sanjiv Shah MD Date: 2023.04.26 09:05:47 -04'00' **Date:**
Glendon Henry, MD **Senior Medical Director**	**Sanjiv Shah, MD** **Chief Medical Officer**

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Medical Guideline Disclaimer:

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, MetroPlus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(includingclinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. 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 and/or paidfor by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and website links are accurate at time of publication.