MetroPlus Health

# Policy and Procedure

| Title: Tecartus | Division: Medical Management<br>Department: Utilization Management |
|---|---|
| Approval Date: 4/26/2022 | LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP |
| Effective Date: 4/26/2022 | Policy Number: UM-MP335 |
| Review Date: 4/25/2023 | Cross Reference Number: |
| Retired Date: | Page 1 of 9 |

1. **POLICY DESCRIPTION:**
   Medical Oncology – Anti-CD19 CAR-T immunotherapy, Tecartus (Brexucabtagene autoleucel)

2. **RESPONSIBLE PARTIES:**
   Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

3. **DEFINITIONS:**
   Tecartus is a CD19-directed genetically modified autologous T cell immunotherapy that binds to CD19-expressing cancer cells and normal B cells. Studies demonstrated that following anti-CD19 CAR T cell engagement with CD19-expressing target cells, the CD28 and CD3-zeta co-stimulatory domains activate downstream signaling cascades that lead to T cell activation, proliferation, acquisition of effector functions, and secretion of inflammatory cytokines and chemokines. This sequence of events leads to killing of CD19-expressing cells.

   Tecartus is indicated for the treatment of:
   - Adult patients with relapsed or refractory mantle cell lymphoma (MCL)
   - Adult patients with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL)

   All other uses for Tecartus are considered experimental and investigational.

4. **POLICY:**
   Tecartus will be considered medically necessary when the following conditions of coverage have been met:

   **Initial Request:**
   **Mantle cell lymphoma (MCL) that is refractory or in relapse.**
   A. Member is 18 years of age or older **AND**
   B. Member has a diagnosis of refractory or relapsed mantle cell lymphoma (MCL) as defined as disease progression after their last regimen or refractory disease to their most recent therapy **AND**
   C. The member has had previous treatment with both chemoimmunotherapy and a bruton tyrosine kinase inhibitor (e.g., ibrutinib, acalabrutinib) **AND**
   D. Member has documentation of CD19 positive disease **AND**
   E. Member has an ECOG performance status of 0 to 2 (See Appendix C)

F. Member has not previously been treated with CAR-T therapy, including Tecartus **AND**
G. The member has adequate and stable kidney, liver, pulmonary and cardiac function **AND**
H. Member does not have human immunodeficiency virus (HIV), active Hepatitis B or C, active uncontrolled infection and any autoimmune disease requiring immune suppression **AND**
I. The member does not have an active inflammatory disorder **AND**
J. The medication will be dosed according to FDA guidelines
    a. Tecartus target dose: 2 x 10(6) chimeric antigen receptor (CAR)-positive viable T cells/kg IV (max dose: 2 x 10(8) CAR-positive viable T cells)

    **AND**
K. Healthcare facility/provider has enrolled in the Tecartus REMS and has training on the management of cytokine release syndrome (CRS) and neurological toxicities (See Appindices A and B)

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

A. Member is 18 years of age or older **AND**
B. The below diagnostic criteria are met **AND**
    a. Member has Philadelphia chromosome-negative disease that is relapsed or refractory as defined as one of the following:
        i. Primary refractory disease
        ii. First relapse with remission of 12 months or less
        iii. Relapsed or refractory disease after at least 2 previous lines of systemic therapy
        iv. Relapsed or refractory disease after allogeneic stem cell transplant **OR**
    b. Member has Philadelphia chromosome-positive disease and meets any of the following:
        i. The member has relapsed or refractory disease despite treatment with at least 2 different tyrosine kinase inhibitors (TKIs) (e.g., bosutinib, dasatinib, imatinib, nilotinib, ponatinib)
        ii. The member is intolerant to TKI therapy
C. The member has morphological disease in the bone marrow (≥5% blasts) **AND**
D. Member has an ECOG performance status of 0 to 2 (See Appendix C) **AND**
E. Member has not previously been treated with CAR-T therapy, including Kymirah **AND**
F. The member has adequate and stable kidney, liver, pulmonary and cardiac function **AND**

G. Member does not have human immunodeficiency virus (HIV), active Hepatitis B or C, active uncontrolled infection and any autoimmune disease requiring immune suppression **AND**
H. The member does not have an active inflammatory disorder **AND**
I. The medication will be dosed according to FDA guidelines
    a. Tecartus target dose: 1 x 10(6) chimeric antigen receptor (CAR)-positive viable T cells/kg IV (Max dose: 1 x 10(8) CAR-positive viable T cells)
    **AND**
J. Healthcare facility/provider has enrolled in the Tecartus REMS and has training on the management of cytokine release syndrome (CRS) and neurological toxicities (See Appindices A and B)

**Renewal Request:**
Repeat administration of Tecartus is investigational and will not be covered.

## 5. LIMITATIONS/EXCLUSIONS

Tecartus is not indicated for acute lymphoblastic leukemia (ALL) that is in remission.

## 6. APPLICABLE PROCEDURE CODES:

| CPT | 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 |

## 7. APPLICABLE DIAGNOSIS CODES:

| CODE | Description |
|---|---|
| C83.11 | Mantle cell lymphoma, lymph nodes of head, face, and neck |
| C83.12 | Mantle cell lymphoma, intrathoracic lymph nodes |
| C83.13 | Mantle cell lymphoma, intra-abdominal lymph nodes |
| C83.14 | Mantle cell lymphoma, lymph nodes of axilla and upper limb |
| C83.15 | Mantle cell lymphoma, lymph nodes of inguinal region and lower limb |
| C83.16 | Mantle cell lymphoma, intrapelvic lymph nodes |
| C83.17 | Mantle cell lymphoma, spleen |

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| C83.18 | Mantle cell lymphoma, lymph nodes of multiple sites |
| C83.19 | Mantle cell lymphoma, extranodal and solid organ sites |
| C91.00 | Acute lymphoblastic leukemia not having achieved remission |
| C91.02 | Acute lymphoblastic leukemia, in relapse |

## 8. REFERENCES:


1. Tecartus [package insert]. Los Angeles, CA: Kite Pharma; October 2021.
2. Study to evaluate the efficacy of Brexucabtagene Autoleucel (KTE-X19) in participants with relapsed/refractory mantle cell lymphoma - full text view. Study to Evaluate the Efficacy of Brexucabtagene Autoleucel (KTE-X19) in Participants With Relapsed/Refractory Mantle Cell Lymphoma - Full Text View - ClinicalTrials.gov. https://clinicaltrials.gov/ct2/show/study/NCT02601313?term=BREXUCABTAGENE&draw=2&rank=3. Published August 2021. Accessed April 7, 2022.
3. The NCCN Drugs & Biologics Compendium® © 2021 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed June 1, 2021.
4. The NCCN Clinical Practice Guidelines in Oncology® B-Cell Lymphomas (Version4.2021).© 2021 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed June 1, 2021.
5. Wang M, Munoz J, Goy A, et al. KTE-X19 CAR T-Cell Therapy in Relapsed or Refractory Mantle-Cell Lymphoma. NEJM 2020; 382:1331-1342.
6. Shah BD, Ghobadi A, Oluwole OO, et al. KTE-X19 for relapsed or refractory adult B-cell acute lymphoblastic leukaemia: phase 2 results of the single-arm, open-label, multicentre ZUMA-3 study. Lancet. 2021;398(10299):491-502.


## 9. APPENDIX A: CRS Grading and Management Guideline

| CRS Grade | Tocilizumab | Corticosteroids |
|---|---|---|
| **Grade 1**<br><br>Symptoms require symptomatic treatment only (e.g., fever, nausea, fatigue, headache, myalgia, malaise). | If not improving after 24 hours, administer tocilizumab 8 mg/kg intravenously over 1 hour (not to exceed 800 mg). | Not applicable |
| **Grade 2** | Administer tocilizumab 8 mg/kg intravenously over 1 hour (not to | Manage per Grade 3 if no improvement |

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|---|---|---|
| Symptoms require and respond to moderate intervention.<br>Oxygen requirement less than 40% FiO2 or hypotension responsive to fluids or low dose of one vasopressor or Grade 2 organ toxicity. | exceed 800 mg). Repeat tocilizumab every 8 hours as needed if not responsive to IV fluids or increasing supplemental oxygen. Limit to a maximum of 3 doses in a 24-hour period; maximum total of 4 doses if no clinical improvement in the signs and symptoms of CRS.<br>If improving, discontinue tocilizumab. | within 24 hours after starting tocilizumab.<br><br>If improving, taper corticosteroids. |
| **Grade 3**<br><br>Symptoms require and respond to aggressive intervention.<br>Oxygen requirement greater than or equal to 40% FiO2 or hypotension requiring high-dose or multiple vasopressors or Grade 3 organ toxicity or Grade 4 transaminitis. | Administer tocilizumab 8 mg/kg IV over 1 hour (not to exceed 800 mg). Repeat tocilizumab every 8 hours as needed if not responsive to IV fluids or increasing supplemental oxygen. Limit to a maximum of 3 doses in a 24-hour period; maximum total of 4 doses if no clinical improvement in the signs and symptoms of CRS.<br>If improving, discontinue tocilizumab. | Administer methylprednisolone 1 mg/kg IV twice daily or equivalent dexamethasone (e.g., 10 mg intravenously every 6 hours) until Grade 1, then taper corticosteroids.<br>If improving, manage as Grade 2.<br>If not improving, manage as Grade 4. |
| **Grade 4**<br><br>Life-threatening symptoms. Requirements for ventilator support or continuous venovenous hemodialysis (CVVHD), or Grade 4 organ toxicity (excluding transaminitis). | Administer tocilizumab 8 mg/kg IV over 1 hour (not to exceed 800 mg). Repeat tocilizumab every 8 hours as needed if not responsive to IV fluids or increasing supplemental oxygen. Limit to a maximum of 3 doses in a 24-hour period; maximum total of 4 doses if no clinical improvement in the signs and symptoms of CRS.<br>If improving, discontinue tocilizumab. | Administer methylprednisolone 1000 mg IV per day for 3 days.<br>If improving, taper corticosteroids, and manage as Grade 3.<br>If not improving, consider alternate immunosuppressants. |

**10. APPENDIX B: Neurologic Toxicity Grading and Management Guidance**

| Neurologic Event | Concurrent CRS | No Concurrent CRS |
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|---|---|---|
| **Grade 1**<br><br>Examples include:<br>Somnolence – mild drowsiness or sleepiness<br>Confusion – mild disorientation<br>Encephalopathy – mild limiting of ADLs<br>Dysphasia – not impairing ability to communicate | If not improving after 24 hours, administer tocilizumab 8 mg/kg intravenously over 1 hour (not to exceed 800 mg). | Supportive care |
| **Grade 2**<br><br>Examples include:<br>Somnolence – moderate limiting instrumental ADLs<br>Confusion – moderate disorientation<br>Encephalopathy – limiting instrumental ADLs<br>Dysphasia - moderate impairing ability to communicate spontaneously<br>Seizure(s) | Administer tocilizumab 8 mg/kg IV over 1 hour (not to exceed 800 mg). Repeat tocilizumab every 8 hours as needed if not responsive to IV fluids or increasing supplemental oxygen. Limit to a maximum of 3 doses in a 24-hour period; maximum total of 4 doses if no clinical improvement in the signs and symptoms of CRS.<br><br>If not improving within 24 hours after starting tocilizumab, administer dexamethasone 10 mg IV every 6 hours until the event is Grade 1 or less, then taper corticosteroids.<br>If improving, discontinue tocilizumab.<br>If still not improving, manage as Grade 3 | Administer dexamethasone 10 mg intravenously every 6 hours until the event is Grade 1 or less.<br>If improving, taper corticosteroids. |
| | Consider non-sedating, anti-seizure medicines (e.g., levetiracetam) for seizure prophylaxis. | |
| **Grade 3**<br><br>Examples include:<br>Somnolence – obtundation or stupor<br>Confusion – severe disorientation | Administer tocilizumab 8 mg/kg IV over 1 hour (not to exceed 800 mg). Repeat tocilizumab every 8 hours as needed if not responsive to IV fluids or increasing supplemental oxygen. Limit to a maximum of 3 doses in a 24-hour period; maximum total of 4 doses if no | Administer dexamethasone 10 mg IV every 6 hours.<br><br>Continue dexamethasone use until the event is |

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| Encephalopathy – limiting self-care ADLs<br>Dysphasia – severe receptive or expressive characteristics, impairing ability to read, write, or communicate intelligibly | clinical improvement in the signs and symptoms of CRS.<br><br>In addition, administer dexamethasone 10 mg IV with the first dose of tocilizumab and repeat dose every 6 hours. Continue dexamethasone use until the event is Grade 1 or less, then taper corticosteroids.<br>If improving, discontinue tocilizumab and manage as Grade 2.<br>If still not improving, manage as Grade 4 | Grade 1 or less, then taper corticosteroids.<br>If not improving, manage as Grade 4. |
| | Consider non-sedating anti-seizure medicines (e.g., levetiracetam) for seizure prophylaxis | |
| **Grade 4**<br><br>Life-threatening consequences<br>Urgent intervention indicated<br>Requirement for mechanical ventilation<br>Consider cerebral edema | Administer tocilizumab 8 mg/kg IV over 1 hour (not to exceed 800 mg). Repeat tocilizumab every 8 hours as needed if not responsive to IV fluids or increasing supplemental oxygen. Limit to a maximum of 3 doses in a 24-hour period; maximum total of 4 doses if no clinical improvement in the signs and symptoms of CRS.<br><br>Administer methylprednisolone 1000 mg intravenously per day with first dose of tocilizumab and continue methylprednisolone 1000 mg intravenously per day for 2 more days.<br>If improving, then manage as Grade 3.<br>If not improving, consider alternate immunosuppressants. | Administer methylprednisolone 1000 mg IV per day for 3 days.<br>If improving, then manage as Grade 3.<br>If not improving, consider alternate immunosuppressants. |
| | Consider non-sedating anti-seizure medicines (e.g., levetiracetam) for seizure prophylaxis | |

**11. Appendix C: Eastern Cooperative Oncology Group Performance**

| Grade | ECOG |
|---|---|
| 0 | Fully active, able to carry on all pre-disease performance without restriction |
| 1 | Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work |
| 2 | Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours |
| 3 | Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours |
| 4 | Completely disabled; cannot carry on any selfcare; totally confined to bed or chair |
| 5 | Dead |

**REVISION LOG:**

| REVISIONS | DATE |
|---|---|
| Creation date | 4/14/2022 |
| Annual review | 4/25/2023 |

| Approved: | Date: | Approved: | Date: |
|---|---|---|---|
| Glendon Henry<br>Digitally signed by Glendon Henry<br>Date: 2023.04.26 07:45:23 -04'00' | | Sanjiv Shah MD<br>Digitally signed by Sanjiv Shah MD<br>Date: 2023.04.26 09:07:21 -04'00' | |
| **Glendon Henry, MD**<br>**Senior Medical Director** | | **Sanjiv Shah, MD**<br>**Chief Medical Officer** | |

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| **Retired Date:** | **Page 9 of 9** |

**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(including clinical 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 andor paid for 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.

MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.