CareSource

PHARMACY POLICY STATEMENT
Indiana Medicaid

DRUG NAME	Kymriah (tisagenlecleucel)
BILLING CODE	Q2040 (1 unit = 250 million T cells)
BENEFIT TYPE	Carved out to FFS (fee-for-service) benefit
SITE OF SERVICE ALLOWED	N/A
COVERAGE REQUIREMENTS	Prior Authorization is required and reviews will be performed by CareSource and forward to IN Medicaid for a final decision and payment
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Kymriah (tisagenlecleucel) is a product that is carved out from managed care benefits and is included in the Indiana Medicaid Fee-For-Service (FFS) program. Requests for authorization of this product will be reviewed by CareSource using the criteria below and forwarded to Indiana Medicaid FFS for a final decision.

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ACUTE LYMPHOBLASTIC LEUKEMIA (ALL) – for autologous use only

For **initial** authorization:

1. Member is 3-25 years of age and has documentation of CD19 tumor expression; AND
2. Member has B-cell acute lymphoblastic leukemia that is refractory or in second or later relapse as defined by **one** of the following:
   a) 2nd or greater Bone Marrow (BM) relapse;
   b) Any BM relapse after allogeneic stem cell transplantation (SCT) and must be > 6 months from SCT at the time of CAR-T cell immunotherapy infusion;
   c) Refractory as defined by not achieving a complete remission (CR) after 2 cycles of a standard chemotherapy regimen chemotherapy regimen or chemorefractory as defined by not achieving a CR after 1 cycle of standard chemotherapy for relapse leukemia;
   d) Member with Philadelphia chromosome positive (Ph+) acute lymphoblastic leukemia that is intolerant to or have failed 2 lines of tyrosine kinase inhibitor (TKI) therapy (e.g. imatinib mesylate (Gleevec), dasatinib (Sprycel), nilotinib (Tasigna) or ponatinib (Iclusig)), or if TKI therapy is contraindicated;
   e) Member is not eligible for allogeneic SCT; AND
3. Member has been screened for hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV) prior to collection of cells (leukapheresis); AND
4. Healthcare facility/provider has enrolled in the Kymriah REMS and has training on the management of cytokine release syndrome (CRS) and neurological toxicities; AND
5. Member must be premedicated with acetaminophen and an H1-antihistamine, and tocilizumab (Actemra) must be available in healthcare facility prior to infusion; AND
6. Member has a life expectancy > 12 weeks; AND
7. Member does **not** have history of ALL of the following:
   a) Prior CAR-T therapy;
   b) Concomitant genetic syndrome (e.g., Fanconi anemia, Kostmann syndrome, Shwachman syndrome or any other known bone marrow failure syndrome);
   c) Burkitt's lymphoma/leukemia;

d) Malignancy, except carcinoma in situ of the skin or cervix treated with curative intent and with no evidence of active disease;
e) Prior treatment with gene therapy product;
f) Presence of Grade 2 to 4 acute or extensive chronic graft-versus-host disease (GVHD);
g) Active or latent hepatitis B or active hepatitis C or HIV.

8. **Dosage allowed:** Weight 50 kg or less: administer 0.2 to 5.0 x 10^6CAR-positive viable T cells per kg body weight intravenously. Weight above 50 kg: administer 0.1 to 2.5 x 10^8 total CAR-positive viable T cells (non-weight based) intravenously.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Kymriah will not be reauthorized for continued therapy.

LARGE B-CELL LYMPHOMA – for autologous use only

For **initial** authorization:
1. Member is being use for adult member (18 years old or older) with has relapsed or refractory large B-cell lymphoma (diffuse large B-cell lymphoma (DLBCL) not otherwise specified, high grade B-cell lymphoma, or DLBCL arising from follicular lymphoma); AND
2. Member has received ≥ 2 lines of chemotherapy, including rituximab and anthracycline, or relapsed following autologous hematopoietic stem cell transplantation (HSCT); AND
3. Member does **not** have ALL of the following:
   a) Active central nervous system malignancy;
   b) Prior allogenic HSCT;
   c) ECOG performance status ≥ 2;
   d) Creatinine clearance < 60;
   e) Alanine aminotransferase > 5 times normal;
   f) Cardiac ejection fraction < 45%;
   g) Absolute lymphocyte concentration less than 300/µL;
   h) Active replication of or prior infection with hepatitis B or active hepatitis C (HCV RNA positive);
   i) HIV positive; AND
4. Healthcare facility/provider has enrolled in the Kymriah REMS and has training on the management of cytokine release syndrome (CRS) and neurological toxicities; AND
5. Member must be premedicated with acetaminophen and an H1-antihistamine, and tocilizumab (Actemra) must be available in healthcare facility prior to infusion; AND
6. Member has a life expectancy > 12 weeks; AND
7. Member has not received prior CAR-T therapy.
8. **Dosage allowed:** Administer 0.6 to 6.0 x 10^8 CAR-positive viable T cells.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Kymriah will not be reauthorized for continued therapy.

CareSource considers Kymriah (tisagenlecleucel) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Primary central nervous system lymphoma

DATE	ACTION/DESCRIPTION
10/24/2017	New policy for Kymriah created.

05/01/2018	Carve out information added—No longer paid for by CareSource. CareSource will review authorization requests and final decision on coverage and payment with be made by IN Medicaid.
08/27/2018	New indication of Large B-cell lymphoma was added. Criteria expanded for ALL diagnosis for member's disease history requirement.

References:

1. Kymriah [package insert]. East Hanover, NJ; Novartis Pharmaceuticals Corp., May 2018.
2. The Leukemia & Lymphoma Society (LLS). Ph-Positive ALL Therapy. Available at https://www.lls.org/leukemia/acute-lymphoblastic-leukemia/treatment/ph-positive-all-therapy.
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. Accessed in October, 2017.
4. Maude SL, et al. Tisagenlecleucel in Children and Young Adults with B-Cell Lymphoblastic Leukemia. N Engl J Med. 2018;378(5):439-448. [PubMed 29385370]
5. Schuster SJ, et al. Primary analysis of Juliet: a global, pivotal, phase 2 trial of CTL019 in adult patients with relapsed or refractory diffuse large B-cell lymphoma. Blood. 2017;130(s1):577 [Abstract 577 from 2017 ASH annual meeting].
6. NCCN Guidelines. Acute Lymphoblastic Leukemia. V.1.2018
7. NCCN Guidelines. Non-Hodgkins Lymphoma. V.4.2018.

Effective date: 09/07/2018
Revised date: 08/27/2018