

Title: Yescarta (axicabtagene ciloleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP230
Review Date: 4/23/2024	Cross Reference Number:
Retired Date:	Page 1 of 11

I. POLICY DESCRIPTION

Immunological Agent, Yescarta (Rx)

II. RESPONSIBLE PARTIES

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

III. DEFINITIONS

Yescarta (Axicabtagene ciloleucel) is a CD19-directed genetically modified autologous T-cell immunotherapy which binds to CD19-expressing cancer cells and normal B cells. As studies have shown, 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. This results in secretion of inflammatory cytokines and chemokines which relays messages that coordinate the immune system to fend off attackers. As a result, this sequence of events leads to killing of CD19-expressing cells.

Yescarta is indicated for the treatment of:

Adult patients with large B-cell lymphoma that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy.

Adult patients with relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, primary mediastinal large B-cell lymphoma, 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.

IV. POLICY

For the Medicare and UltraCare lines of business, MetroPlusHealth determines medical necessity based on applicable Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD).

<https://www.cms.gov/medicare-coverage-database/search.aspx>

Title: Yescarta (axicabtagene ciloleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP230
Review Date: 4/23/2024	Cross Reference Number:
Retired Date:	Page 2 of 11

For all non-Medicare LOBs:

Yescarta will be considered medically necessary once the following coverage criteria is met. Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

INITIAL REQUEST:

1. Adult Large B-cell lymphoma

A. Member is 18 years of age or older;

AND

B. Member has a diagnosis confirmed by submitted documentation including chart notes consistent with ONE of the following:

a. Large B-cell lymphoma;

OR

b. Diffuse large B-cell lymphoma (DLBCL) not otherwise specified;

OR

c. Primary mediastinal large B-cell lymphoma;

OR

d. High grade B-cell lymphoma;

OR

e. DLBCL arising from follicular lymphoma;

AND

C. ONE of the following:

a. Member has disease refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy

(Examples of chemoimmunotherapy include:

RGCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone);

Pola-R-CHP (polatuzumab vedotin-piiq, rituximab, cyclophosphamide, doxorubicin, prednisone));

OR

b. Member has relapsed or refractory disease after two or more lines of systemic therapy

(Examples of systemic therapy include:

CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) + Gazyva

(obinutuzumab intravenous infusion) or rituximab products;

Title: Yescarta (axicabtagene ciloleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP230
Review Date: 4/23/2024	Cross Reference Number:
Retired Date:	Page 3 of 11

CVP (cyclophosphamide, vincristine, prednisone) + rituximab products; lenalidomide + rituximab products));

AND

D. Member has an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 1;

AND

E. Member has not received any live vaccines within the past 6 weeks;

AND

F. Member does not have an active systemic infection or inflammatory disorder;

AND

G. Member has not previously been treated with Yescarta or any other CAR-T therapy;

AND

H. The requesting provider belongs to a healthcare facility that has enrolled in the Yescarta REMS (Risk Evaluation and Mitigation Strategy) program and training has been given to providers on the management of cytokine release syndrome (CRS) and neurological toxicities (treatment centers can be found [here](#));

AND

I. Authorization is for no more than one dose

2. Adult Follicular lymphoma

A. Member is 18 years of age or older;

AND

B. Member has a diagnosis of Follicular lymphoma confirmed by submitted documentation including chart notes;

AND

C. Member has relapsed or refractory disease after trial and failure or contraindication to at least TWO lines of therapy that includes a combination of an anti-CD 20 monoclonal antibody (e.g., Rituxan (rituximab), Gazyva (Obinutuzumab)) and an alkylating agent (e.g., bendamustine, cyclophosphamide, chlorambucil);

(Examples of systemic therapy include:

Bendamustine + obinutuzumab or rituximab;

CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) + binutuzumab or rituximab;

CVP (cyclophosphamide, vincristine, prednisone) + obinutuzumab or rituximab;

Lenalidomide + rituximab;

Chlorambucil ± rituximab;

Cyclophosphamide ± rituximab))

AND

Title: Yescarta (axicabtagene ciloleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP230
Review Date: 4/23/2024	Cross Reference Number:
Retired Date:	Page 4 of 11

- D. Member has an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 1;
AND
- E. Member has not received any live vaccines within the past 6 weeks;
AND
- F. Member does not have an active systemic infection or inflammatory disorder;
AND
- G. Member has not previously been treated with Yescarta or any other CAR-T therapy;
AND
- H. The requesting provider belongs to a healthcare facility that has enrolled in the Yescarta REMS (Risk Evaluation and Mitigation Strategy) program and training has been given to providers on the management of cytokine release syndrome (CRS) and neurological toxicities (treatment centers can be found [here](#));
AND
- I. Authorization is for no more than one dose

RENEWAL REQUEST:

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

V. LIMITATIONS/EXCLUSIONS:

- Repeat administration of Yescarta is considered experimental and investigational because there have been no established studies to demonstrate effectiveness
- Yescarta is also considered experimental or investigational for the following indications due to no established studies of clinical efficacy:
 - Acute lymphoblastic leukemia (ALL)
 - Indolent non-Hodgkin lymphoma (NHL)
 - Mantle cell lymphoma
 - Marginal zone lymphoma
 - Primary central nervous system (CNS) lymphoma
- History of allogeneic stem cell transplantation or prior CAR-T cell therapy or other genetically modified T cell therapy
- Ejection fraction < 50% or evidence of pericardial effusion
- History or presence of CNS disorder such as seizure disorder, cerebrovascular ischemia/hemorrhage, dementia, cerebellar disease, or any autoimmune disease with CNS involvement

Title: Yescarta (axicabtagene ciloleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP230
Review Date: 4/23/2024	Cross Reference Number:
Retired Date:	Page 5 of 11

VI. APPLICABLE PROCEDURE CODES

CPT Code	Description
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-CD19 CAR T cells, including leukopheresis and dose preparation procedures, per infusion

VII. APPLICABLE DIAGNOSIS CODES:

CODE	Description
C82.00	Follicular lymphoma grade I, unspecified site
C82.01	Follicular lymphoma grade I, lymph nodes of head, face, and neck
C82.02	Follicular lymphoma grade I, intrathoracic lymph nodes
C82.03	Follicular lymphoma grade I, intra-abdominal lymph nodes
C82.04	Follicular lymphoma grade I, lymph nodes of axilla and upper limb
C82.05	Follicular lymphoma grade I, lymph nodes of inguinal region and lower limb
C82.06	Follicular lymphoma grade I, intrapelvic lymph nodes
C82.07	Follicular lymphoma grade I, spleen
C82.08	Follicular lymphoma grade I, lymph nodes of multiple sites
C82.09	Follicular lymphoma grade I, extranodal and solid organ sites
C82.10	Follicular lymphoma grade II, unspecified site
C82.11	Follicular lymphoma grade II, lymph nodes of head, face, and neck
C82.12	Follicular lymphoma grade II, intrathoracic lymph nodes
C82.13	Follicular lymphoma grade II, intra-abdominal lymph nodes
C82.14	Follicular lymphoma grade II, lymph nodes of axilla and upper limb
C82.15	Follicular lymphoma grade II, lymph nodes of inguinal region and lower limb
C82.16	Follicular lymphoma grade II, intrapelvic lymph nodes
C82.17	Follicular lymphoma grade II, spleen
C82.18	Follicular lymphoma grade II, lymph nodes of multiple sites
C82.19	Follicular lymphoma grade II, extranodal and solid organ sites
C82.20	Follicular lymphoma grade III, unspecified, unspecified site
C82.21	Follicular lymphoma grade III, unspecified, lymph nodes of head, face, and neck
C82.22	Follicular lymphoma grade III, unspecified, intrathoracic lymph nodes
C82.23	Follicular lymphoma grade III, unspecified, intra-abdominal lymph nodes
C82.24	Follicular lymphoma grade III, unspecified, lymph nodes of axilla and upper limb
C82.25	Follicular lymphoma grade III, unspecified, lymph nodes of inguinal region and lower limb
C82.26	Follicular lymphoma grade III, unspecified, intrapelvic lymph nodes

Title: Yescarta (axicabtagene ciloleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP230
Review Date: 4/23/2024	Cross Reference Number:
Retired Date:	Page 6 of 11

C82.27	Follicular lymphoma grade III, unspecified, spleen
C82.28	Follicular lymphoma grade III, unspecified, lymph nodes of multiple sites
C82.29	Follicular lymphoma grade III, unspecified, extranodal and solid organ sites
C82.30	Follicular lymphoma grade IIIa, unspecified site
C82.31	Follicular lymphoma grade IIIa, lymph nodes of head, face, and neck
C82.32	Follicular lymphoma grade IIIa, intrathoracic lymph nodes
C82.33	Follicular lymphoma grade IIIa, intra-abdominal lymph nodes
C82.34	Follicular lymphoma grade IIIa, lymph nodes of axilla and upper limb
C82.35	Follicular lymphoma grade IIIa, lymph nodes of inguinal region and lower limb
C82.36	Follicular lymphoma grade IIIa, intrapelvic lymph nodes
C82.37	Follicular lymphoma grade IIIa, spleen
C82.38	Follicular lymphoma grade IIIa, lymph nodes of multiple sites
C82.39	Follicular lymphoma grade IIIa, extranodal and solid organ sites
C82.40	Follicular lymphoma grade IIIb, unspecified site
C82.41	Follicular lymphoma grade IIIb, lymph nodes of head, face, and neck
C82.42	Follicular lymphoma grade IIIb, intrathoracic lymph nodes
C82.43	Follicular lymphoma grade IIIb, intra-abdominal lymph nodes
C82.44	Follicular lymphoma grade IIIb, lymph nodes of axilla and upper limb
C82.45	Follicular lymphoma grade IIIb, lymph nodes of inguinal region and lower limb
C82.46	Follicular lymphoma grade IIIb, intrapelvic lymph nodes
C82.47	Follicular lymphoma grade IIIb, spleen
C82.48	Follicular lymphoma grade IIIb, lymph nodes of multiple sites
C82.49	Follicular lymphoma grade IIIb, extranodal and solid organ sites
C82.50	Diffuse follicle center lymphoma, unspecified site
C82.51	Diffuse follicle center lymphoma, lymph nodes of head, face, and neck
C82.52	Diffuse follicle center lymphoma, intrathoracic lymph nodes
C82.53	Diffuse follicle center lymphoma, intra-abdominal lymph nodes
C82.54	Diffuse follicle center lymphoma, lymph nodes of axilla and upper limb
C82.55	Diffuse follicle center lymphoma, lymph nodes of inguinal region and lower limb
C82.56	Diffuse follicle center lymphoma, intrapelvic lymph nodes
C82.57	Diffuse follicle center lymphoma, spleen
C82.58	Diffuse follicle center lymphoma, lymph nodes of multiple sites
C82.59	Diffuse follicle center lymphoma, extranodal and solid organ sites
C82.60	Cutaneous follicle center lymphoma, unspecified site
C82.61	Cutaneous follicle center lymphoma, lymph nodes of head, face, and neck
C82.62	Cutaneous follicle center lymphoma, intrathoracic lymph nodes

Title: Yescarta (axicabtagene ciloleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP230
Review Date: 4/23/2024	Cross Reference Number:
Retired Date:	Page 7 of 11

C82.63	Cutaneous follicle center lymphoma, intra-abdominal lymph nodes
C82.64	Cutaneous follicle center lymphoma, lymph nodes of axilla and upper limb
C82.65	Cutaneous follicle center lymphoma, lymph nodes of inguinal region and lower limb
C82.66	Cutaneous follicle center lymphoma, intrapelvic lymph nodes
C82.67	Cutaneous follicle center lymphoma, spleen
C82.68	Cutaneous follicle center lymphoma, lymph nodes of multiple sites
C82.69	Cutaneous follicle center lymphoma, extranodal and solid organ sites
C82.80	Other types of follicular lymphoma, unspecified site
C82.81	Other types of follicular lymphoma, lymph nodes of head, face, and neck
C82.82	Other types of follicular lymphoma, intrathoracic lymph nodes
C82.83	Other types of follicular lymphoma, intra-abdominal lymph nodes
C82.84	Other types of follicular lymphoma, lymph nodes of axilla and upper limb
C82.85	Other types of follicular lymphoma, lymph nodes of inguinal region and lower limb
C82.86	Other types of follicular lymphoma, intrapelvic lymph nodes
C82.87	Other types of follicular lymphoma, spleen
C82.88	Other types of follicular lymphoma, lymph nodes of multiple sites
C82.89	Other types of follicular lymphoma, extranodal and solid organ sites
C82.90	Follicular lymphoma, unspecified, unspecified site
C82.91	Follicular lymphoma, unspecified, lymph nodes of head, face, and neck
C82.92	Follicular lymphoma, unspecified, intrathoracic lymph nodes
C82.93	Follicular lymphoma, unspecified, intra-abdominal lymph nodes
C82.94	Follicular lymphoma, unspecified, lymph nodes of axilla and upper limb
C82.95	Follicular lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C82.96	Follicular lymphoma, unspecified, intrapelvic lymph nodes
C82.97	Follicular lymphoma, unspecified, spleen
C82.98	Follicular lymphoma, unspecified, lymph nodes of multiple sites
C82.99	Follicular lymphoma, unspecified, extranodal and solid organ sites
C83.30	Diffuse large B-cell lymphoma, unspecified site
C83.31	Diffuse large B-cell lymphoma, lymph nodes of head, face, and neck
C83.32	Diffuse large B-cell lymphoma, intrathoracic lymph nodes
C83.33	Diffuse large B-cell lymphoma, intra-abdominal lymph nodes
C83.34	Diffuse large B-cell lymphoma, lymph nodes of axilla and upper limb
C83.35	Diffuse large B-cell lymphoma, lymph nodes of inguinal region and lower limb
C83.36	Diffuse large B-cell lymphoma, intrapelvic lymph nodes

Title: Yescarta (axicabtagene ciloleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP230
Review Date: 4/23/2024	Cross Reference Number:
Retired Date:	Page 8 of 11

C83.37	Diffuse large B-cell lymphoma, spleen
C83.38	Diffuse large B-cell lymphoma, lymph nodes of multiple sites
C83.39	Diffuse large B-cell lymphoma, extranodal and solid organ sites
C85.10	Unspecified B-cell lymphoma, unspecified site
C85.11	Unspecified B-cell lymphoma, lymph nodes of head, face, and neck
C85.12	Unspecified B-cell lymphoma, intrathoracic lymph nodes
C85.13	Unspecified B-cell lymphoma, intra-abdominal lymph nodes
C85.14	Unspecified B-cell lymphoma, lymph nodes of axilla and upper limb
C85.15	Unspecified B-cell lymphoma, lymph nodes of inguinal region and lower limb
C85.16	Unspecified B-cell lymphoma, intrapelvic lymph nodes
C85.17	Unspecified B-cell lymphoma, spleen
C85.18	Unspecified B-cell lymphoma, lymph nodes of multiple sites
C85.19	Unspecified B-cell lymphoma, extranodal and solid organ sites
C85.20	Mediastinal (thymic) large B-cell lymphoma, unspecified site
C85.21	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of head, face, and neck
C85.22	Mediastinal (thymic) large B-cell lymphoma, intrathoracic lymph nodes
C85.23	Mediastinal (thymic) large B-cell lymphoma, intra-abdominal lymph nodes
C85.24	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of axilla and upper limb
C85.25	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of inguinal region and lower limb
C85.26	Mediastinal (thymic) large B-cell lymphoma, intrapelvic lymph nodes
C85.27	Mediastinal (thymic) large B-cell lymphoma, spleen
C85.28	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of multiple sites
C85.29	Mediastinal (thymic) large B-cell lymphoma, extranodal and solid organ sites

Title: Yescarta (axicabtagene ciloleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP230
Review Date: 4/23/2024	Cross Reference Number:
Retired Date:	Page 9 of 11

VIII. REFERENCES

1. Food and Drug Administration. FDA approves CAR-T cell therapy to treat adults with certain types of large B-cell lymphoma. FDA: Silver Spring, MD. October 18, 2017. Available at: <https://www.fda.gov/news-events/press-announcements/fda-approves-car-t-cell-therapy-treat-adults-certain-types-large-b-cell-lymphoma>
2. Highlights of Prescribing Information. Yescarta (axicabtagene ciloleucel) suspension for intravenous infusion. Initial U.S. Approval: October 2017. Kite Pharma, Inc. Santa Monica, CA. Available at: <https://www.gilead.com/-/media/files/pdfs/medicines/oncology/yescarta/yescarta-pi.pdf>
3. IBM Micromedex. Available at: micromedexsolutions.com
4. Kite Pharma, Inc. A Phase 1-2 multi-center study evaluating KTE-C19 in subjects with refractory aggressive non-hodgkin lymphoma (ZUMA-1). NCT 02348216. Updated December 14, 2017. Available at: <https://clinicaltrials.gov/ct2/show/NCT02348216?term=zuma+kte&rank=2>.
5. The NCCN Clinical Practice Guidelines in Oncology® B-Cell Lymphomas (Version 1.2024; January 18, 2024).© 2021 National Comprehensive Cancer Network, Inc. <https://www.nccn.org>
6. Yescarta [Product Information], Kite Pharma, Santa Monica, California; March 2024. Available at: <https://www.gilead.com/-/media/files/pdfs/medicines/oncology/yescarta/yescarta-pi.pdf>
7. The NCCN Clinical Practice Guidelines in Oncology® B-Cell Lymphomas (Version 1.2024; January 18, 2024).© 2021 National Comprehensive Cancer Network, Inc. <https://www.nccn.org>.

Title: Yescarta (axicabtagene ciloleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP230
Review Date: 4/23/2024	Cross Reference Number:
Retired Date:	Page 10 of 11

REVISION LOG:

REVISIONS	DATE
Creation date	3/30/2018
Review	3/15/2019
Annual Review	6/8/2020
Annual Review	9/1/2021
Annual Review	8/30/2022
Annual Review	8/29/2023
Review	4/23/2024
Update LOBs to remove Medicare and Ultracare	8/9/2024

Approved:	Date:	Approved:	Date:
David Ackman, MD VP of Medical Directors		Sanjiv Shah, MD Chief Medical Officer	

Medical Guideline Disclaimer:

Property of Metro Plus Health Plan. All rights reserved. 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

Title: Yescarta (axicabtagene ciloleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP230
Review Date: 4/23/2024	Cross Reference Number:
Retired Date:	Page 11 of 11

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 and/or 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.