MetroPlus Health

Policy and Procedure

Title: Breyanzi (lisocabtagene maraleucel)	**Division: Medical Management** **Department: Utilization Management**
Approval Date: 1/31/2023	**LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, Goldcare, Essential Plan, QHP**
Effective Date: 1/31/2023	**Policy Number: UM-MP347**
Review Date: 1/28/2025	**Cross Reference Number:**
Retired Date:	**Page 1 of 24**

POLICY DESCRIPTION:

Medical Oncology – Anti-CD19 CAR-T immunotherapy, Breyanzi (lisocabtagene maraleucel)

I. RESPONSIBLE PARTIES:

Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

II. DEFINITIONS:

Breyanzi (lisocabtagene maraleucel) is an autologous genetically modified immunotherapy that targets cancer and normal B cells that express an antigen called CD19. The patient's T cells are collected and modified to have a chimeric antigen receptor (CAR), which will allow them to identify and eliminate CD19 expressing cells. The CAR consists of a FMC63 monoclonal antibody-derived single chain variable fragment (scFv), a hinge region called IgG4, CD28 transmembrane domain, 4-1BB (CD137) costimulatory doman and a CD3 zeta activation domain. Once the CAR binds to CD19 it will induce T cell activation and proliferation, release of pro-inflammatory cytokines and cytotoxic killing of the target cells.

III. 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).

For all non-Medicare LOBs:

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

INITIAL REQUEST:

1. **Large B-cell lymphoma (LBCL) that is refractory or in relapse:**
   - **A.** Member is 18 years of age or older;

   AND
   - **B.** Member has a diagnosis of relapsed or refractory large B-cell lymphoma (LBCL) including ANY of the following:
     - **a.** Diffuse large B-cell lymphoma (DLBCL) not otherwise specified including DLBCL arising from indolent lymphoma;

     OR
     - **b.** High-grade B-cell lymphoma;

OR

c. Primary mediastinal large B-cell lymphoma;

OR

d. Follicular lymphoma grade 3B;

AND

C. Member has ONE of the following:

a. Refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy *(Examples of chemoimmunotherapy include: RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone); Pola-R-CHP (polatuzumab vedotin-piiq, rituximab, cyclophosphamide, doxorubicin, prednisone))*;

OR

b. Refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplantation (HSCT) due to comorbidities or age *(Examples of chemoimmunotherapy include: RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone); Pola-R-CHP (polatuzumab vedotin-piiq, rituximab, cyclophosphamide, doxorubicin, prednisone))*;

OR

c. Relapsed or refractory disease after 2 or more lines of systemic therapy *(Examples of systemic therapy include: CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) + Gazyva (obinutuzumab intravenous infusion) or rituximab products; 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 does not have ANY of the following *(Note: If member has any of the following then attestation needs to be provided which states that member is being followed by a cardiologist or any other qualified physician per condition to monitor member if Breyanzi is still to be given per physician's discretion)*:

a. History of primary malignancy that has not been in remission for at least 2 years prior to Breyanzi consideration (exceptions include: non-melanoma skin cancer, definitively-treated stage 1 solid tumor with a low risk of recurrence, curatively treated localized prostate cancer, and cervical carcinoma in situ on biopsy or a squamous intraepithelial lesion on a Pap smear);

OR

b. History or presence of clinically relevant central nervous system (CNS) pathology **(**e.g., seizure disorders, paresis, aphasia, stroke, severe brain injuries, organic brain syndrome, cerebellar disease, dementia, Parkinson's disease, and or psychosis);

OR

c. Active uncontrolled infection including human immunodeficiency virus (HIV), Hepatitis B or C and Cytomegalovirus (CMV), systemic fungal, bacterial, viral, or other infection that is not controlled;

OR

d. Autoimmune disease requiring systemic immunosuppression;

OR

e. Presence of acute or extensive chronic graft versus host disease (GVHD);

OR

f. Progressive vascular tumor invasion, thrombosis, or embolism;

OR

g. Venous thrombosis or embolism requiring treatment but not managed on a stable regimen of anticoagulation;

AND

F. Member has not received hematopoetic stem cell transplantation (HSCT) in last 90 days prior to leukapheresis;

AND

G. Member will not receive live vaccines 6 weeks prior to lymphodepleting chemotherapy and during administration of Breyanzi and until immune recovery after treatment;

AND

H. Member has adequate organ function as defined by ALL of the following *(Note: If member does not meet any of the following then attestation needs to be provided which states that member is being followed by a qualified physician per condition to monitor member if Breyanzi is still to be given per physician's discretion)*:

a. Member has creatinine clearance > 30 mL/min;

AND

b. Alanine aminotransferase ≤ 5 times the upper limit of normal;

AND

c. Left ventricular ejection fraction (LVEF) ≥ 40%;

AND

I. ONE of the following:

a. Member has no prior use of CD-19 targeted therapy;

OR

b. If member has used a previous CD-19 targeted therapy they must re-biopsy and have a CD-19 positive disease;

AND

J. Member has no prior use of CAR-T therapy including Breyanzi;

AND

K. Breyanzi will not be given concurrently with other CAR-T immunotherapies [Kymriah (Tisagenlecleucel), Yescarta (Axicabtagene ciloleucel), Tecartus (brexucabtagene autoleucel)];

AND

L. Breyanzi will be prescribed by the consultation of a hematologist or oncologist;

AND

M. Member has adequate vascular access for leukapheresis procedure**;**

AND

N. Member has adequate bone marrow function to receive lymphodepleting chemotherapy as determined by the prescriber;

AND

O. Member is not currently enrolled in Large B-cell lymphoma clinical trial or is ineligible for clinical trial enrollment;

AND

P. Breyanzi will be given accordingly based on the FDA approved dosing;

AND

Q. Member will receive Breyanzi at a healthcare facility enrolled in the Breyanzi REMS and are aware of how to manage cytokine release syndrome and neurological toxicities (See Appendices A and B)

Initial Duration of Approval: *One single dose per lifetime*

2. Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) that is relapsed or refractory

A. Member is 18 years of age or older;

AND

B. Member has a diagnosis of relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL);

AND

C. Member has received prior treatment with at least two lines of therapy, including at least one drug from ALL of the following drug classes unless contraindicated:

a. Bruton tyrosine kinase (BTK) inhibitor (e.g., Imbruvica (ibrutinib), Calquence (acalabrutinib), Brukinsa (zanubrutinib));

AND

b. B-cell lymphoma 2 (BCL-2) inhibitor (e.g., Venclexta (venetoclax));

AND

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

AND

E. Member does not have ANY of the following *(Note: If member has any of the following then attestation needs to be provided which states that member is being followed by a cardiologist or any other qualified physician per condition to monitor member if Breyanzi is still to be given per physician's discretion)*:

a. History of primary malignancy that has not been in remission for at least 2 years prior to Breyanzi consideration (exceptions include: non-melanoma skin cancer, definitively-treated stage 1 solid tumor with a low risk of recurrence, curatively treated localized prostate cancer, and cervical carcinoma in situ on biopsy or a squamous intraepithelial lesion on a Pap smear);

OR

b. History or presence of clinically relevant central nervous system (CNS) pathology (e.g., seizure disorders, paresis, aphasia, stroke, severe brain injuries, organic brain syndrome, cerebellar disease, dementia, Parkinson's disease, and or psychosis);

OR

c. Active uncontrolled infection including human immunodeficiency virus (HIV), Hepatitis B or C and Cytomegalovirus (CMV), systemic fungal, bacterial, viral, or other infection that is not controlled;

OR

d. Presence of acute or extensive chronic graft versus host disease (GVHD);

OR

e. Richter's transformation (i..e, a rare complication of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) that occurs when the disease transforms into a more aggressive type of lymphoma);

OR

f. Progressive vascular tumor invasion, thrombosis, or embolism;

OR

g. Venous thrombosis or embolism requiring treatment but not managed on a stable regimen of anticoagulation

AND

F. Member will not receive live vaccines 6 weeks prior to lymphodepleting chemotherapy and during administration of Breyanzi and until immune recovery after treatment;

AND

G. Member has adequate organ function as defined by ALL of the following *(Note: If member does not meet any of the following then attestation needs to be provided which states that member is being followed by a qualified physician per condition to monitor member if Breyanzi is still to be given per physician's discretion)*:

- **a.** Member has creatinine clearance > 30 mL/min;

  AND

- **b.** Alanine aminotransferase ≤ 5 times the upper limit of normal;

  AND

- **c.** Left ventricular ejection fraction (LVEF) ≥ 40%;

AND

H. ONE of the following:

- **a.** Member has no prior use of CD-19 targeted therapy;

  OR

- **b.** If member has used a previous CD-19 targeted therapy they must re-biopsy and have a CD-19 positive disease;

AND

I. Member has no prior use of CAR-T therapy including Breyanzi;

AND

J. Breyanzi will not be given concurrently with other CAR-T immunotherapies [Kymriah (Tisagenlecleucel), Yescarta (Axicabtagene ciloleucel), Tecartus (brexucabtagene autoleucel)];

AND

K. Breyanzi will be prescribed by the consultation of a hematologist or oncologist;

AND

L. Member has adequate vascular access for leukapheresis procedure;

AND

M. Member has adequate bone marrow function to receive lymphodepleting chemotherapy as determined by the prescriber;

AND

N. Member is not currently enrolled in Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) clinical trial or is ineligible for clinical trial enrollment;

AND

O. Breyanzi will be given accordingly based on the FDA approved dosing;

AND

P. Member will receive Breyanzi at a healthcare facility enrolled in the Breyanzi REMS and are aware of how to manage cytokine release syndrome and neurological toxicities (See Appendices A and B)

Initial Duration of Approval: *One single dose per lifetime*

3. Follicular Lymphoma (FL) that is relapsed or refractory

A. Member is 18 years of age or older;

AND

B. Member has received prior treatment with at least two lines of therapy;

AND

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

AND

D. Member does not have ANY of the following *(Note: If member has any of the following then attestation needs to be provided which states that member is being followed by a cardiologist or any other qualified physician per condition to monitor member if Breyanzi is still to be given per physician's discretion)*:

a. Evidence or history of composite Diffuse large B-cell lymphoma (DLBCL) (i.e., a rare type of lymphoma where two distinct subtypes of lymphoma, one of which is always diffuse large B-cell lymphoma (DLBCL), coexist within the same tissue or organ) and FL, or of transformed FL (i.e., when FL evolves into a faster-growing, more aggressive lymphoma);

OR

b. The World Health Organization (WHO) subclassification of duodenal-type FL;

OR

c. History of primary malignancy that has not been in remission for at least 2 years prior to Breyanzi consideration with the exception of non-invasive malignancies;

OR

d. Active uncontrolled infection including human immunodeficiency virus (HIV), Hepatitis B or C and Cytomegalovirus (CMV), systemic fungal, bacterial, viral, or other infection that is not controlled;

OR

e. Presence of acute or extensive chronic graft versus host disease (GVHD);

OR

f. Autoimmune disease requiring immunosuppression;

AND

E. Member has not received hematopoetic stem cell transplantation (HSCT) in last 90 days prior to leukapheresis;

AND

F. Member will not receive live vaccines 6 weeks prior to lymphodepleting chemotherapy and during administration of Breyanzi and until immune recovery after treatment;

AND

G. Member has adequate organ function as defined by ALL of the following *(Note: If member does not meet any of the following then attestation needs to be provided which states that member is being followed by a qualified physician per condition to monitor member if Breyanzi is still to be given per physician's discretion)*:

- **a.** Member has creatinine clearance > 30 mL/min;

  AND

- **b.** Alanine aminotransferase ≤ 5 times the upper limit of normal;

  AND

- **c.** Left ventricular ejection fraction (LVEF) ≥ 40%;

AND

H. Member has no prior use of CAR-T therapy including Breyanzi;

AND

I. Breyanzi will not be given concurrently with other CAR-T immunotherapies [Kymriah (Tisagenlecleucel), Yescarta (Axicabtagene ciloleucel), Tecartus (brexucabtagene autoleucel)];

AND

J. Breyanzi will be prescribed by the consultation of a hematologist or oncologist;

AND

K. Member has adequate vascular access for leukapheresis procedure;

AND

L. Member is not currently enrolled in Follicular Lymphoma clinical trial or is ineligible for clinical trial enrollment;

AND

M. Breyanzi will be given accordingly based on the FDA approved dosing;

AND

N. Member will receive Breyanzi at a healthcare facility enrolled in the Breyanzi REMS and are aware of how to manage cytokine release syndrome and neurological toxicities (See Appendices A and B)

Initial Duration of Approval: *One single dose per lifetime*

4. **Mantle Cell Lymphoma (MCL) that is relapsed or refractory**
   - **A.** Member is 18 years of age or older;

   AND
   - **B.** Member has received prior treatment with at least two lines of therapy, including a Bruton tyrosine kinase (BTK) inhibitor (e.g., Imbruvica (ibrutinib), Calquence (acalabrutinib), Brukinsa (zanubrutinib)) unless contraindicated;

   AND
   - **C.** Member has an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 1;

   AND
   - **D.** Member does not have ANY of the following *(Note: If member has any of the following then attestation needs to be provided which states that member is being followed by a cardiologist or any other qualified physician per condition to monitor member if Breyanzi is still to be given per physician's discretion)*:
     - **a.** History of primary malignancy that has not been in remission for at least 2 years prior to Breyanzi consideration (exceptions include: non-melanoma skin cancer, definitively-treated stage 1 solid tumor with a low risk of recurrence, curatively treated localized prostate cancer, and cervical carcinoma in situ on biopsy or a squamous intraepithelial lesion on a Pap smear);

     OR
     - **b.** History or presence of clinically relevant central nervous system (CNS) pathology (e.g., seizure disorders, paresis, aphasia, stroke, severe brain injuries, organic brain syndrome, cerebellar disease, dementia, Parkinson's disease, and or psychosis);

     OR
     - **c.** Active uncontrolled infection including human immunodeficiency virus (HIV), Hepatitis B or C and Cytomegalovirus (CMV), systemic fungal, bacterial, viral, or other infection that is not controlled;

     OR
     - **d.** Autoimmune disease requiring immunosuppression;

     OR
     - **e.** Presence of acute or extensive chronic graft versus host disease (GVHD);

OR

f. Progressive vascular tumor invasion, thrombosis, or embolism;

OR

g. Venous thrombosis or embolism requiring treatment but not managed on a stable regimen of anticoagulation;

AND

E. Member has not received hematopoetic stem cell transplantation (HSCT) in last 90 days prior to leukapheresis;

AND

F. Member will not receive live vaccines 6 weeks prior to lymphodepleting chemotherapy and during administration of Breyanzi and until immune recovery after treatment;

AND

G. Member has adequate organ function as defined by ALL of the following *(Note: If member does not meet any of the following then attestation needs to be provided which states that member is being followed by a qualified physician per condition to monitor member if Breyanzi is still to be given per physician's discretion)*:

a. Member has creatinine clearance > 30 mL/min;

AND

b. Alanine aminotransferase ≤ 5 times the upper limit of normal;

AND

c. Left ventricular ejection fraction (LVEF) ≥ 40%;

AND

H. ONE of the following:

a. Member has no prior use of CD-19 targeted therapy;

OR

b. If member has used a previous CD-19 targeted therapy they must re-biopsy and have a CD-19 positive disease;

AND

I. Member has no prior use of CAR-T therapy including Breyanzi;

AND

J. Breyanzi will not be given concurrently with other CAR-T immunotherapies [Kymriah (Tisagenlecleucel), Yescarta (Axicabtagene ciloleucel), Tecartus (brexucabtagene autoleucel)];

AND

K. Breyanzi will be prescribed by the consultation of a hematologist or oncologist;

AND

L. Member has adequate vascular access for leukapheresis procedure;

AND

M. Member has adequate bone marrow function to receive lymphodepleting chemotherapy as determined by the prescriber;

AND

N. Member is not currently enrolled in Mantle Cell Lymphoma clinical trial or is ineligible for clinical trial enrollment;

AND

O. Breyanzi will be given accordingly based on the FDA approved dosing;

AND

P. Member will receive Breyanzi at a healthcare facility enrolled in the Breyanzi REMS and are aware of how to manage cytokine release syndrome and neurological toxicities (See Appendices A and B)

Initial Duration of Approval: *One single dose per lifetime*

RENEWAL REQUEST:
Breyanzi will not be renewed for additional requests as this is a single dose therapy.

Renewal Duration of Approval: *Not Applicable*

IV. LIMITATIONS/ EXCLUSIONS:

- Breyanzi is considered to be experimental and investigational if prescribed for indications that have not been approved by the FDA.
- Repeat infusions of breyanzi are considered to be experimental and investigational because there have been no established studies to demonstrate effectiveness.
- Breyanzi is only available at Qualified Treatment Centers.
- Breyanzi is not indicated for the treatment of patients with primary central nervous system lymphoma

V. APPLICABLE PROCEDURE CODES:

CPT	Description
Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-CD19 car-positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic dose

VI. 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
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
C82.80	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
C83.00	Small cell B-cell lymphoma, unspecified site
C83.01	Small cell B-cell lymphoma, lymph nodes of head, face, and neck
C83.02	Small cell B-cell lymphoma, intrathoracic lymph nodes
C83.03	Small cell B-cell lymphoma, intra-abdominal lymph nodes
C83.04	Small cell B-cell lymphoma, lymph nodes of axilla and upper limb
C83.05	Small cell B-cell lymphoma, lymph nodes of inguinal region and lower limb
C83.06	Small cell B-cell lymphoma, intrapelvic lymph nodes

C83.07	Small cell B-cell lymphoma, spleen
C83.08	Small cell B-cell lymphoma, lymph nodes of multiple sites
C83.09	Small cell B-cell lymphoma, extranodal and solid organ sites
C83.10	Mantle Cell Lymphoma, Unspecified Site
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
C83.18	Mantle Cell Lymphoma, Lymph Nodes Of Multiple Sites
C83.19	Mantle Cell Lymphoma, 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
C83.37	Diffuse large B-cell lymphoma, spleen
C83.38	Diffuse large B-cell lymphoma, lymph nodes of multiple sites
C83.90	Non-follicular (diffuse) lymphoma, unspecified, unspecified site
C83.91	Non-follicular (diffuse) lymphoma, unspecified, lymph nodes of head, face, and neck
C83.92	Non-follicular (diffuse) lymphoma, unspecified, intrathoracic lymph nodes
C83.93	Non-follicular (diffuse) lymphoma, unspecified, intra-abdominal lymph nodes
C83.94	Non-follicular (diffuse) lymphoma, unspecified, lymph nodes of axilla and upper limb
C83.95	Non-follicular (diffuse) lymphoma, unspecified, lymph nodes of inguinal region and lower limb

C83.96	Non-follicular (diffuse) lymphoma, unspecified, intrapelvic lymph nodes
C83.97	Non-follicular (diffuse) lymphoma, unspecified, spleen
C83.98	Non-follicular (diffuse) lymphoma, unspecified, lymph nodes of multiple sites
C83.99	Non-follicular (diffuse) lymphoma, unspecified, 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
C85.80	Other specified types of non-Hodgkin lymphoma, unspecified site
C85.81	Other specified types of non-Hodgkin lymphoma, lymph nodes of head, face, and neck
C85.82	Other specified types of non-Hodgkin lymphoma, intrathoracic lymph nodes

C85.83	Other specified types of non-Hodgkin lymphoma, intra-abdominal lymph nodes
C85.84	Other specified types of non-Hodgkin lymphoma, lymph nodes of axilla and upper limb
C85.85	Other specified types of non-Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C85.86	Other specified types of non-Hodgkin lymphoma, intrapelvic lymph nodes
C85.87	Other specified types of non-Hodgkin lymphoma, spleen
C85.88	Other specified types of non-Hodgkin lymphoma, lymph nodes of multiple sites
C85.89	Other specified types of non-Hodgkin lymphoma, extranodal and solid organ sites
C91.10	Chronic Lymphocytic Leukemia Of B-Cell Type Not Having Achieved Remission
C91.12	Chronic Lymphocytic Leukemia Of B-Cell Type In Relapse
Z51.12	Encounter for antineoplastic immunotherapy

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VIII. APPENDICES:

Appendix A: CRS Grading and Management Guidance

CRS Grade	Tocilizumab	Corticosteroids*
Grade 1 Fever	If less than 72 hours after infusion, consider tocilizumab 8 mg/kg IV over 1 hour (MAX 800 mg). If 72 hours or more after infusion, treat symptomatically.	If less than 72 hours after infusion, consider dexamethasone 10 mg IV every 24 hours. If 72 hours or more after infusion, treat symptomatically.
Grade 2 Symptoms require and respond to moderate intervention. Oxygen requirement less than 40% fraction of inspired oxygen (FiO2), or hypotension responsive to fluids or low dose of one	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 intravenous fluids or increasing supplemental oxygen. **Limit tocilizumab to a maximum of 3 doses in a 24-hour period; maximum total of 4 doses.**	If less than 72 hours after infusion, administer dexamethasone 10 mg IV every 12 to 24 hours. If 72 hours or more after infusion, consider

vasopressor, or Grade 2 organ toxicity.		dexamethasone 10 mg IV every 12 to 24 hours.
	If no improvement within 24 hours or rapid progression, repeat tocilizumab and escalate dose and frequency of dexamethasone 10 to 20 mg IV every 6 to 12 hours. If no improvement or continued rapid progression, maximize dexamethasone, switch to high-dose methylPREDNISolone 2 mg/kg if needed. After 2 doses of tocilizumab, consider alternative immunosuppressants. **Do not exceed 3 doses of tocilizumab in 24 hours, or 4 doses in total.**	
Grade 3 Symptoms require and respond to aggressive intervention. Oxygen requirement 40% FiO2 or greater, or hypotension requiring high-dose or multiple	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 intravenous fluids or increasing supplemental oxygen. **Limit tocilizumab to a maximum of 3 doses in a 24-hour period; maximum total of 4 doses.**	Administer dexamethasone 20 mg IV every 12 hours.

<table>
<tr><td>vasopressors, or Grade 3 organ toxicity, or Grade 4 transaminitis.</td><td colspan="2">If no improvement within 24 hours or rapid progression of CRS, repeat tocilizumab and escalate dose and frequency of dexamethasone 10 to 20 mg IV every 6 to 12 hours.

If no improvement or continued rapid progression, maximize dexamethasone, switch to high-dose methylPREDNISolone 2 mg/kg if needed. After 2 doses of tocilizumab, consider alternative immunosuppressants. Do not exceed 3 doses of tocilizumab in 24 hours, or 4 doses in total.</td></tr>
<tr><td rowspan="2">Grade 4

Life-threatening symptoms

Requirements for ventilator support or continuous veno-venous hemodialysis (CVVHD) or Grade 4 organ toxicity (excluding transaminitis).</td><td>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 intravenous fluids or increasing supplemental oxygen.

Limit tocilizumab to a maximum of 3 doses in a 24-hour period; maximum total of 4 doses.</td><td>Administer dexamethasone 20 mg IV every 6 hours.</td></tr>
<tr><td colspan="2">If no improvement within 24 hours or rapid progression of CRS, escalate tocilizumab and corticosteroid use.

If no improvement or continued rapid progression, maximize dexamethasone, switch to high-dose methylPREDNISolone 2 mg/kg if needed.

After 2 doses of tocilizumab, consider alternative immunosuppressants. Do not exceed 3 doses of tocilizumab in 24 hours, or 4 doses in total.</td></tr>
<tr><td colspan="3">*If corticosteroids are initiated, continue corticosteroids for at least 3 doses or until complete resolution of symptoms, and consider corticosteroid taper.</td></tr>
</table>

Appendix B: Neurologic Toxicity Grading and Management Guidance

Neurologic Toxicity Grade	Corticosteroids and Antiseizure Medications
Grade 1	Start non-sedating, antiseizure medicines (eg, levetiracetam) for seizure prophylaxis.

	If 72 hours or more after infusion, observe the patient. If less than 72 hours after infusion, consider dexamethasone 10 mg IV every 12 to 24 hours for 2 to 3 days.
Grade 2	Start non-sedating, antiseizure medicines (eg, levetiracetam) for seizure prophylaxis. Administer dexamethasone 10 mg IV every 12 hours for 2 to 3 days, or longer for persistent symptoms. Consider taper for a total steroid exposure of greater than 3 days. If no improvement after 24 hours or worsening of neurologic toxicity, increase the dose and/or frequency of dexamethasone up to a maximum of 20 mg IV every 6 hours. If no improvement after another 24 hours, rapidly progressing symptoms, or life-threatening complications arise, give methylPREDNISolone 2 mg/kg loading dose, followed by 2 mg/kg divided 4 times a day; taper within 7 days.
Grade 3	Start non-sedating, antiseizure medicines (eg, levetiracetam) for seizure prophylaxis. Administer dexamethasone 10 to 20 mg IV every 8 to 12 hours. Steroids are not recommended for isolated Grade 3 headaches. If no improvement after 24 hours or worsening of neurologic toxicity, escalate to methylprednisolone (dose and frequency as per Grade 2). If cerebral edema is suspected, consider hyperventilation and hyperosmolar therapy. Give high-dose methylPREDNISolone 1 to 2 g, repeat every 24 hours if needed; taper as clinically indicated and cyclophosphamide 1.5 g/m(2).
Grade 4	Start non-sedating, antiseizure medicines (eg, levetiracetam) for seizure prophylaxis. Administer dexamethasone 20 mg IV every 6 hours.

	If no improvement after 24 hours or worsening of neurologic toxicity, escalate to methylPREDNISolone (dose and frequency as per Grade 2). If cerebral edema is suspected, consider hyperventilation and hyperosmolar therapy. Give high-dose methylPREDNISolone 1 to 2 g, repeat every 24 hours if needed; taper as clinically indicated, and cyclophosphamide 1.5 g/m(2).

REVISION LOG:

REVISIONS	DATE
Creation date	1/31/2023
Annual update	1/22/2024
Update LOBs to remove Medicare and Ultracare	8/12/2024
Annual Review	1/28/2025

MetroPlus Health

Policy and Procedure

Title: Breyanzi (lisocabtagene maraleucel)	**Division: Medical Management** **Department: Utilization Management**
Approval Date: 1/31/2023	**LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, Goldcare, Essential Plan, QHP**
Effective Date: 1/31/2023	**Policy Number: UM-MP347**
Review Date: 1/28/2025	**Cross Reference Number:**
Retired Date:	**Page 24 of 24**

Approved: **Date:** David Ackman Digitally signed by David Ackman Date: 2025.01.30 14:28:34 -05'00'	**Approved:** **Date:** Sanjiv Shah MD Digitally signed by Sanjiv Shah MD Date: 2025.01.31 08:25:40 -05'00'
David Ackman, MD **VP of Medical Director**	**Sanjiv Shah, MD** **Chief Medical Officer**

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.