Reference number(s)
4514-A

STANDARD MEDICARE PART B MANAGEMENT

BREYANZI (lisocabtagene maraleucel)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indication

Breyanzi is a CD19-directed genetically modified autologous T-cell immunotherapy indicated for the treatment of adult patients with large B-cell lymphoma, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (NOS) (including DLBCL arising from indolent lymphoma), high grade B-cell lymphoma, primary mediastinal large B-cell lymphoma, and follicular lymphoma grade 3B who have:

1. Refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy; or
2. 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; or
3. Relapsed or refractory disease after two or more lines of systemic therapy

Limitations of use: Breyanzi is not indicated for the treatment of patients with primary central nervous system lymphoma.

B. Compendial Uses

1. Human immunodeficiency virus(HIV)-related B-cell lymphomas (including HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus 8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specific)
2. Monomorphic post-transplant lymphoproliferative disorder (B-cell type)
3. Pediatric primary mediastinal large B-cell lymphoma

All other indications will be assessed on an individual basis. Submissions for indications other than those enumerated in this policy should be accompanied by supporting evidence from Medicare approved compendia.

II. EXCLUSIONS

Coverage will not be provided for members with any of the following exclusions:

A. Primary central nervous system lymphoma
B. Previous treatment course with the requested medication or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy.
C. ECOG performance status greater than or equal to 3 (member is not ambulatory and not capable of all self-care, confined to bed or chair more than 50% of waking hours)

D. Inadequate and unstable kidney, liver or cardiac function
E. Active hepatitis B, active hepatitis C or any active uncontrolled infection
F. Active graft versus host disease
G. Active inflammatory disorder

III. DOCUMENTATION

The following documentation must be available, upon request, for all submissions: Chart notes, medical record documentation or claims history supporting previous lines of therapy.

IV. CRITERIA FOR INITIAL APPROVAL

A. Adult Large B-cell Lymphomas

Authorization of 3 months may be granted for treatment of B-cell lymphomas in members 18 years of age or older when either of the following criteria are met:

1. The member has received prior treatment with two or more lines of systemic therapy and has any of the following B-cell lymphoma subtypes:
    i. Diffuse large B-cell lymphoma (DLBCL) [including DLBCL not otherwise specified (NOS), follicular lymphoma grade 3, DLBCL arising from indolent lymphomas]
    ii. High grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma NOS)
    iii. Primary mediastinal large B-cell lymphoma
    iv. HIV-related B-cell lymphomas (including HIV-related DLBCL, primary effusion lymphoma, and human herpesvirus 8 (HHV8)-positive diffuse large B-cell lymphoma NOS)
    v. Monomorphic post-transplant lymphoproliferative disorder (B-cell type)
2. The member has received prior treatment with first-line chemoimmunotherapy and has any of the following B-cell lymphoma subtypes:
    i. Diffuse large B-cell lymphoma (DLBCL) [including DLBCL not otherwise specified (NOS), follicular lymphoma grade 3, DLBCL arising from indolent lymphomas]
    ii. High grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma NOS)
    iii. Primary mediastinal large B-cell lymphoma
    iv. HIV-related B-cell lymphomas (including HIV-related DLBCL, primary effusion lymphoma, and human herpesvirus 8 (HHV8)-positive diffuse large B-cell lymphoma NOS)
    v. Monomorphic post-transplant lymphoproliferative disorder (B-cell type)

B. Pediatric Primary Mediastinal Large B-cell Lymphoma

Authorization of 3 months may be granted for treatment of primary mediastinal large B-cell lymphoma in members less than 18 years of age when the member has received prior therapy with at least two prior chemoimmunotherapy regimens and achieved partial response

I. SUMMARY OF EVIDENCE

The contents of this policy were created after examining the following resources:

1. The prescribing information for Breyanzi.
2. The available compendium
    a. National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
    b. Micromedex DrugDex

   c. American Hospital Formulary Service- Drug Information (AHFS-DI)
   d. Lexi-Drugs
   e. Clinical Pharmacology
3. NCCN Guideline: B-cell Lymphomas
4. NCCN Guideline: Pediatric aggressive mature B-cell lymphomas
5. National Coverage Determination: Chimeric Antigen Receptor (CAR) T-cell Therapy

After reviewing the information in the above resources, the FDA-approved indications listed in the prescribing information for Breyanzi are covered in addition to the following:

1. Human immunodeficiency virus(HIV)-related B-cell lymphomas (including HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus 8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specific)
2. Monomorphic post-transplant lymphoproliferative disorder (B-cell type)
3. Pediatric primary mediastinal large B-cell lymphoma

II. EXPLANATION OF RATIONALE

Support for FDA-approved indications can be found in the manufacturer's prescribing information.

Support for using Breyanzi to treat human immunodeficiency virus (HIV)-related B-cell lymphomas, pediatric primary mediastinal large B-cell lymphoma, and monomorphic post-transplant lymphoproliferative disorder can be found in the NCCN Drugs and Biologics Compendium. Use of information in the NCCN Drugs and Biologics Compendium for off-label use of drugs and biologicals in an anti-cancer chemotherapeutic regimen is supported by the Medicare Benefit Policy Manual, Chapter 15, section 50.4.5 (Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen).

All FDA and compendial indications are covered according to the conditions outlined in National Coverage Determination Manual section 110.24 (Chimeric Antigen Receptor [CAR] T-cell Therapy).

V. REFERENCES

1. Breyanzi [package insert]. Bothell, WA: Juno Therapeutics Inc.; July 2022.
2. The NCCN Drugs & Biologics Compendium® © 2023 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed April 13, 2023.
3. The NCCN Clinical Practice Guidelines in Oncology® B-Cell Lymphomas (Version 2.2023). © 2023 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed April 13, 2023.
4. National Coverage Determination (NCD) for Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24-Version 1). https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=374&ncdver=1&DocID=110.24&SearchType=Advanced&bc=EAAAAAIAAAAA&. Accessed April 17, 2023.