| Reference number(s) |
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| 4466-A |

# STANDARD MEDICARE PART B MANAGEMENT

## ELZONRIS (tagraxofusp-erzs)

### 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
Elzonris is a CD123-directed cytotoxin indicated for the treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN) in adults and in pediatric patients 2 years and older.

B. Compendial Use
Blastic plasmacytoid dendritic cell neoplasm (BPDCN)

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. DOCUMENTATION

The following documentation must be available, upon request, for all submissions:
For initial requests: Medical record documentation confirming the member is positive for CD123 expression

### III. CRITERIA FOR INITIAL APPROVAL

**Blastic plasmacytoid dendritic cell neoplasm (BPDCN)**
Authorization of 12 months may be granted for treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN) when the member's disease is positive for CD123 expression and the requested medication will be used as a single agent.

### IV. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must be currently receiving therapy with the requested agent.

Authorization for 12 months may be granted when all of the following criteria are met:
A. The member is currently receiving therapy with the requested medication.
B. The requested medication is being used to treat an indication enumerated in Section III.
C. The member is receiving benefit from therapy. Benefit is defined as:

i. No evidence of unacceptable toxicity while on the current regimen and
ii. No evidence of disease progression while on the current regimen

## V. SUMMARY OF EVIDENCE

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

1. The prescribing information for Elzonris.
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: Acute myeloid leukemia

After reviewing the information in the above resources, the FDA-approved indications listed in the prescribing information for Elzonris are covered.

## VI. EXPLANATION OF RATIONALE

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

Support for using Elzonris as a single agent to treat BPDCN 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).

## VII. REFERENCES

1. Elzonris [package insert]. New York, NY: Stemline Therapeutics, Inc.; November 2022.
2. The NCCN Drugs & Biologics Compendium® © 2023 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed January 6, 2023.