Effective Date **1/15/2023**
Next Review Date… **1/15/2024**
Coverage Policy Number **IP0130**

Lisocabtagene maraleucel

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Related Coverage Resources

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This policy supports medical necessity review for lisocabtagene maraleucel (Breyanzi®).

Medical Necessity Criteria

Lisocabtagene maraleucel (Breyanzi®) is considered medically necessary for the treatment of B-cell Lymphoma when the individual meets ALL of the following criteria:

1. 18 years of age or older
2. **ONE** of the following:
    a. **BOTH** of the following:
        i. **ONE** of the following diagnoses:
            a) Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma
            b) Diffuse large B-cell lymphoma (DLBCL), not otherwise specified
            c) Follicular lymphoma Grade 3B
            d) High-grade B-cell lymphoma

e) Human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma
f) Large B-cell lymphoma
g) Post-transplant lymphoproliferative disorders
h) Primary effusion lymphoma
i) Primary mediastinal large B-cell lymphoma

ii. Received at least **ONE** line of systemic therapy, including **BOTH** of the following:
a) Anti-CD20 monoclonal antibody
b) An anthracycline-containing chemotherapy regimen

b. **BOTH** of the following:
i. Transformed indolent lymphoma to diffuse large B-cell lymphoma
ii. Received **TWO** or more lines of systemic therapy, including **BOTH** of the following:
a) Anti-CD20 monoclonal antibody
b) An anthracycline-containing chemotherapy regimen

3. **ALL** of the following:
a. Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2
b. Does not have primary central nervous system lymphoma
c. Received lymphodepleting chemotherapy prior to infusion of Breyanzi
d. No prior use of CD19-directed CAR-T therapy

CD 19-directed CAR-T therapy examples include: Kymriah® (tisagenlecleucel suspension for intravenous infusion), Tecartus™ (brexucabtagene suspension for intravenous infusion), and Yescarta® (axicabtagene suspension for intravenous infusion).

4. Medication is prescribed by, or in consultation, with a hematologist or oncologist

Dosing for B-cell Lymphoma. The dose is 50 to 110 x 10^6 CAR-positive viable T-cells administered intravenously as a single dose.[1]

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Authorization Duration

Authorization is for a one-time approval.

Conditions Not Covered

Lisocabtagene maraleucel (Breyanzi®) is considered experimental, investigational or unproven for **ANY** other use including the following (this list may not be all inclusive):

Repeat administration of lisocabtagene maraleucel (Breyanzi®).

Coding Information

1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT® Codes	Description
0537T	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day
0538T	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (e.g., cryopreservation, storage)
0539T	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration
0540T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous

HCPCS Codes	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

Background

OVERVIEW

Breyanzi, a CD19-directed genetically modified autologous T-cell immunotherapy, is indicated for the treatment of adults with large B-cell lymphoma including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (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.
- Refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplantation due to age or comorbidities.
- Relapsed or refractory disease after ≥ 2 lines of systemic therapy.

Limitations of use: Breyanzi is not indicated for the treatment of patients with primary central nervous system lymphoma.[1]

Dosing Information

Breyanzi is supplied in separate frozen vials containing the CD8 component and the CD4 component.[1] Each component is supplied in cartons containing one to four vials depending on the concentration of the cryopreserved chimeric antigen receptor (CAR)-positive T-cells. The vials are stored in the vapor phase of liquid nitrogen ≤ -130°C). The dose of Breyanzi is 50 to 110 x 10^6 CAR-positive viable T cells (consisting of a 1:1 mixture of the CD8 and CD4 components), with each component supplied separately in single-dose vials.

Guidelines

The National Comprehensive Cancer Network clinical practice guidelines for B-cell lymphomas (version 5.2022 – July 12, 2022) recommend Breyanzi for the treatment of a variety of lymphomas.[2,3] Breyanzi can be used as second-line and subsequent therapy for relapsed or refractory DLBCL, high-grade B-cell lymphoma, acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma, and post-transplant lymphoproliferative disorders. Breyanzi can also be used as third-line and subsequent therapy for transformed indolent lymphoma to DLBCL.

Safety

Breyanzi has a Boxed Warning regarding cytokine release syndrome (CRS) and neurologic toxicities.[1] Breyanzi is only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Breyanzi REMS.

References

1. Breyanzi® intravenous infusion [prescribing information]. Bothell, WA: Juno Therapeutics; June 2022.
2. The NCCN B-Cell Lymphoma Clinical Practice Guidelines in Oncology (version 5.2022 – July 12, 2022). © 2022 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed July 13, 2022.
3. The NCCN Drugs and Biologics Compendium. © 2022 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on July 13, 2022. Search term: lisocabtagene.