Drug Policy:
Kymriah™ (tisagenlecleucel)

I. PURPOSE
To define and describe the accepted indications for Kymriah (tisagenlecleucel) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

New Century Health (NCH) is responsible for processing all medication requests from network ordering providers. Medications not authorized by NCH may be deemed as not approvable and therefore not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

II. INDICATIONS FOR USE/INCLUSION CRITERIA
A. PREFERRED MEDICATION GUIDANCE FOR INITIAL REQUEST:
1. When health plan Medicaid coverage provisions—including any applicable PDLs (Preferred Drug Lists)—conflict with the coverage provisions in this drug policy, health plan Medicaid coverage provisions take precedence per the Preferred Drug Guidelines OR
2. When health plan Exchange coverage provisions—including any applicable PDLs (Preferred Drug Lists)—conflict with the coverage provisions in this drug policy, health plan Exchange coverage provisions take precedence per the Preferred Drug Guidelines OR
3. For Health Plans that utilize NCH UM Oncology Clinical Policies as the initial clinical criteria, the Preferred Drug Guidelines shall follow NCH L1 Pathways when applicable, otherwise shall follow NCH drug policies AND

4. Continuation requests of previously approved, non-preferred medication are not subject to this provision AND

5. When applicable, generic alternatives are preferred over brand-name drugs.

B. Acute Lymphoblastic Leukemia (ALL)

1. Kymriah (tisagenlecleucel) is being used when the following criteria are met:
   a. Member is 25 years old or younger, and has Acute Lymphoblastic Leukemia with confirmed documentation of CD19 tumor expression (demonstrated in bone marrow or peripheral blood by flow cytometry) AND
   b. Member has experienced disease relapse after allogeneic stem cell transplantation (SCT) and member is ≥ 6 months from above transplantation at the time of infusion OR
   c. Member has relapsed/refractory Philadelphia chromosome-negative B-ALL that has progressed after 2 cycles of a standard chemotherapy regimen for initial diagnosis OR after 1 cycle of standard chemotherapy for relapsed leukemia OR
   d. Member has relapsed/refractory Philadelphia chromosome-positive B-ALL that has progressed after failure of 2 prior regimens, including a TKI-containing regimen.

C. B-Cell Lymphomas

1. Kymriah (tisagenlecleucel) may be used for members who are 18 years of age or older, with Diffuse Large B-Cell Lymphoma, transformed Follicular Lymphoma, high-grade B-cell lymphoma with MYC rearrangement plus rearrangement of BCL2, BCL6, or both genes (i.e., double- or triple-hit lymphoma) with confirmed documentation of CD19 tumor expression. AND

2. Members must have previously received at least two lines of therapy, including rituximab and an anthracycline (for DBCL) AND

3. Either having failed autologous Hematopoietic stem cell transplantation (ASCT) or being ineligible for or not consenting to ASCT.

III. EXCLUSION CRITERIA

A. Kymriah (tisagenlecleucel) is being used after disease progression on or after CAR-T cell therapy directed towards CD19 antigen (Kymriah, Breyanzi, or Yescarta).

B. Member does not have adequate bone marrow reserve defined by ALL of the following:
   1. Absolute neutrophil count (ANC) ≥ 1000/uL
   2. Absolute lymphocyte count (ALC) > 300/uL
   3. Platelet Count ≥ 50,000/uL

C. Member does not have adequate renal, hepatic, cardiac and pulmonary function defined as:
   1. Creatinine clearance ≥ 60 mL/min
   2. Serum ALT ≤5 times the upper limit of normal
   3. Cardiac ejection fraction ≥ 45%, no evidence of pericardial effusion as determined by an echocardiogram (ECHO), and no clinically significant pleural effusion
   4. Baseline oxygen saturation > 91% on room air.

D. History of seizures or other CNS disorder.
E. History of autoimmune disease.
F. Active serious infection.
G. Previous allogeneic transplant.
H. Active CNS involvement with lymphoma.
I. Indications not supported by CMS recognized compendia or acceptable peer reviewed literature.

IV. MEDICATION MANAGEMENT
   A. Please refer to the FDA label/package insert for details regarding these topics.

V. APPROVAL AUTHORITY
   A. Review – Utilization Management Department
   B. Final Approval – Utilization Management Committee

VI. ATTACHMENTS
   A. None

VII. REFERENCES