Drug Policy:

Yescarta™ (axicabtagene ciloleucel)

**I. PURPOSE**

To define and describe the accepted indications for Yescarta (axicabtagene ciloleucel) 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 available, generic alternatives are preferred over brand-name drugs.

B. Non-Hodgkin Lymphomas (NHL)

1. The member has ONE of the following aggressive, CD-19 positive NHL:
   a. Diffuse Large B Cell Lymphoma (DLBCL)
   b. Primary Mediastinal Large B Cell Lymphoma (PMBCL)
   c. Transformed Follicular Lymphoma (TFL) (transformed to Diffuse Large B-Cell or other high grade lymphoma)
   d. High-grade B-cell lymphomas with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma) or high-grade B-cell lymphomas, not otherwise specified
   e. Monomorphic post-transplant lymphoproliferative disorders (B-cell type)
      AND

2. The member has chemotherapy-refractory disease after the following:
   a. Two or more lines of systemic chemotherapy
   b. For DLBCL, two or more lines of systemic chemotherapy, including rituximab and an anthracycline.

C. Follicular Lymphoma

1. Yescarta (axicabtagene ciloleucel) may be used in adult members with CD19 positive relapsed or refractory follicular lymphoma (FL) who have received, and experienced disease progression on two or more lines of systemic therapies, including the combination of an anti-CD20 monoclonal antibody and an alkylating agent (e.g., R-bendamustine, R-CHOP, R-CVP).

III. EXCLUSION CRITERIA

A. Yescarta (axicabtagene ciloleucel) is being used after disease progression with the same regimen or prior CAR therapy or other genetically modified T cell therapy directed toward the CD-19 antigen

B. Concurrent use with other systemic immunosuppressive therapy or live virus vaccines.

C. No documented CD-19 status in lymphoma cells.

D. Does not exceed duration limit as one time administration.

E. The 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) ≥ 100/uL
   3. Platelet Count ≥ 75,000/uL.

F. The member does not have adequate renal, hepatic, cardiac and pulmonary function defined as:
   1. Creatinine clearance ≥ 60 mL/min
   2. Serum ALT/AST <2.5 times the upper limit of normal
3. Total bilirubin <1.5 mg/dl, except in subjects with Gilbert’s syndrome
4. Cardiac ejection fraction ≥ 50%, no evidence of pericardial effusion as determined by an echocardiogram (ECHO), and no clinically significant pleural effusion
5. Baseline oxygen saturation > 92% on room air.

G. Primary central nervous system lymphoma
H. Active central nervous system malignancy
I. History of seizures or other CNS disorder
J. History of autoimmune disease
K. Prior Allogeneic hematopoietic stem cell transplant (HSCT)
L. Active serious infection
M. 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