Breyanzi
(Lisocabtagene maraleucel)

Policy Number: 011

<table>
<thead>
<tr>
<th></th>
<th>Commercial and Qualified Health Plans</th>
<th>MassHealth</th>
<th>Medicare Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization required</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>No Prior Authorization</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Breyanzi is a chimeric antigen receptor T cell therapy (CAR-T), designed to harness the power of the patient’s immune system to recognize and attack their cancer cells. CAR-T is a type of treatment where white blood cells (T cells) are modified in a laboratory to add a gene that helps the patient’s own T cells target their cancer.

**FDA-Approved Indication**
Breyanzi is a B-cell maturation antigen (BCMA)-directed genetically modified autologous T cell immunotherapy for the treatment of:

- Adult patients with relapsed or refractory large B-cell lymphoma (LBCL) after two or more lines of systemic therapy including:
  - Diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from any indolent lymphoma);
  - Primary mediastinal large B-cell lymphoma;
  - High grade B-cell lymphoma; and
  - DLBCL arising from follicular lymphoma grade 3B
- Breyanzi is not indicated for the therapy of primary central nervous system lymphoma.
- Other indications supported by NCCN will be considered on a case-by-case basis.

**Criteria**

1. **Criteria for Initial Approval**

Authorization of a single treatment may be granted to patients 18 years of age or older for treatment of Large B-cell lymphoma (including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, DLBCL arising from any indolent lymphoma, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, and DLBCL arising from follicular lymphoma) when ALL of the following criteria are met:

A. The disease is relapsed or refractory to treatment after two or more lines of systemic therapy.

OR

B. Refractory to first-line chemo or relapse within 12 months of first-line chemo, or refractory to first-line chemo or relapse after first-line chemo and are not eligible for hematopoietic stem cell transplantation (HSCT)

And all of the following:

C. The member has not received any prior FDA approved CD19-directed therapy.

D. The patient does not have primary central nervous system lymphoma.

E. The healthcare facility that dispenses and administers Breyanzi must be enrolled and comply with the Breyanzi Risk Evaluation and Mitigation Strategy known as REMS.

---

1 Exceptions for non-FDA approved CD19 therapies will be reviewed on an individual case by case basis. A detailed medical review will be required.
F. The healthcare facility must have tocilizumab available on site for management of Cytokine Release Syndrome.

2. Required Documentation
   • Documentation of two prior lines of therapy
   • Provider/patient REMS certification/enrollment

3. Duration of Therapy
   • Single treatment course
   • Additional courses of therapy are considered experimental/investigational.

Medicare Variation
Mass General Brigham Health Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations for its Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals are the basis for coverage determinations. When there is no guidance from CMS for the requested service, Mass General Brigham Health Plan’s medical policies are used for coverage determinations. 

At the time of Mass General Brigham Health Plan’s most recent policy review, Medicare has an NCD for Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24).

Codes

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage.

This list of codes applies to commercial and MassHealth plans only.

<table>
<thead>
<tr>
<th>Authorized CPT/HCPSC Codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2054</td>
<td>Lisocabtagene maraleucel, up to 110 million autologous anti-CD19 CAR-positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic dose</td>
</tr>
</tbody>
</table>

Effective
February 2024: Annual review. Removed requirement for CD19 testing.
October 2021: Code update.
July 2021: Effective Date.

References

Breyanzi Prescribing Information. Bristol Myers Squibb; February 2021.


