

Elrexio (elranatamab-bcmm)
Effective 10/01/2026

Plan	☒ MassHealth UPPL ☐ Commercial/Exchange	Program Type	☒ Prior Authorization
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit		☐ Quantity Limit ☐ Step Therapy
Specialty Limitations	N/A		
Contact Information	Medical and Specialty Medications		
	All Plans	Phone: 877-519-1908	Fax: 855-540-3693
Contact Information	Non-Specialty Medications		
	All Plans	Phone: 800-711-4555	Fax: 844-403-1029
Exceptions	N/A		

Overview

Elrexio (elranatamab-bcmm) is indicated for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least four prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody. Because of the risks of cytokine release syndrome (CRS) and neurologic toxicity, Elrexio is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS), called the ELREXFIO REMS

Coverage Guidelines

If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with the requested drug, excluding when the product is obtained as samples or via manufacturer's patient assistance programs

OR

Authorization may be granted for members when all the following criteria are met:

1. Diagnosis of relapsed or refractory multiple myeloma
2. Prescriber is a hematologist or oncologist
3. Appropriate dosing (weight is required)
4. Member is ≥ 18 years of age on treatment date (at time of initial administration)
5. Inadequate response or adverse reaction to **FOUR** lines of systemic therapies or contraindication to **ALL** other lines of systemic therapies
6. Inadequate response or adverse reaction to **ONE** agent from each class or contraindication to **ALL** of the following classes:
 - a. Anti-CD38 monoclonal antibody (e.g., Darzalex (daratumumab), Darzalex Faspro (daratumumabhyaluronidase-fihj), and Sarclisa (isatuximab-irfc))
 - b. Immunomodulatory agent (e.g., Pomalyst (pomalidomide), Revlimid (lenalidomide) and Thalomid (thalidomide))
 - c. Proteasome inhibitor (e.g., bortezomib, Velcade (bortezomib), Kyprolis (carfilzomib), and Ninlaro (ixazomib))

7. Administration will take place in a healthcare facility that has been certified pursuant to the REMS program specific to the treatment being provided

Continuation of Therapy

Reauthorization by prescriber will infer a positive response to therapy.

Limitations

1. Initial and reauthorization approvals will be granted for 6 months.

References

1. Elrexio [package insert]. New York (NY): Pfizer Inc.; 2023 Aug.

Review History

04/10/24 – Created for P&T. Adopted MH criteria for Elrexio to require PA under MB. Effective 5/6/24.

06/11/25 – Reviewed and updated for P&T as part of annual UM review. Updated formatting and references. Removed Appendix to incorporate into approval criteria. Effective 7/1/25

09/10/26 – Reviewed and updated for P&T. Updated formatting. Updated the Overview section to include REMS program. Effective 10/1/26

