

**Elzonris (tagraxofusp-erzs)**  
**Effective 04/01/2023**

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

### Overview

Elzonris® (tagraxofusp-erzs) is a CD123-directed cytotoxin indicated for the treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN) in adults and in pediatric patients two years of age and older.

No PA	Require PA
Alternatives vary by patient age and disease category and may include systemic chemotherapy. Please refer to NCCN guideline for the latest recommendations.	Elzonris® (tagraxofusp-erzs)

### Coverage Guidelines

Authorization may be reviewed on a case by case basis for members who are new to the plan currently receiving treatment with requested medication excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

#### OR

Authorization will be granted when all the following criteria has been met, and documentation has been submitted:

1. Diagnosis of blastic plasmacytoid dendritic cell neoplasm (BPDCN)
2. Prescriber is an oncologist or hematologist
3. Appropriate dosing
4. First infusion will take place in an inpatient setting and subsequent infusions may take place in an outpatient setting with appropriate monitoring

### Continuation of Therapy

Reauthorization by physician will infer a positive response to therapy.

### Limitations

1. Initial approvals will be granted for 3 months.
2. Reauthorizations will be granted for 6 months.

3. Members who have already started treatment on Elzonris® may be approved for any FDA-approved indication.

### **References**

1. Elzonris® (tagraxofusp-erzs) [package insert]. New York (NY): Stemline Therapeutics, Inc.; 2018 Dec.
2. Pemmaraju N, Lane AA, Sweet KL, Stein AS, Vasu S, Blum W, et al. Tagraxofusp in Blastic Plasmacytoid Dendritic-Cell Neoplasm. *N Engl J Med*. 2019 Apr 25;380(17):1628-1637.
3. BPDCN [website on the internet]. Stemline. 2020 Aug [cited 2022 Mar 7]. Available from: <https://bpdcninfo.com/>.
4. IPD Analytics. Elzonris (tagraxofusp-erzs). 2022 Mar [cited 2022 Mar 7]. Data on file.
5. FDA approves first treatment for rare blood disease [press release on the internet]. FDA; 2018 Dec 21 [cited 2022 Mar 7]. Available from: <https://www.fda.gov/news-events/press-announcements/fda-approves-first-treatment-rare-blood-disease>.
6. Gurbuxani S. Blastic plasmacytoid dendritic cell neoplasm. In: Basow DS (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2022 Jan 18 [cited 2022 Mar 7]. Available from: <https://www.uptodate.com/contents/blastic-plasmacytoid-dendritic-cell-neoplasm>.
7. Pagano L, Valentini CG, Grammatico S, Pulsoni A. Blastic plasmacytoid dendritic cell neoplasm: diagnostic criteria and therapeutical approaches. *Br J Haematol*. 2016 Jul;174(2):188-202.

### **Review History**

01/11/23 - Reviewed and created for Jan P&T; matched MH UPPL. Created criteria to be in compliance with Masshealth unified formulary requirements (Effective 4/1/23)

