Mass General Brigham
Health Plan

Elrexfio (elranatamab-bcmm)
Effective 07/01/2025

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

Overview
Elrexfio (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.

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 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. Member's disease is refractory to at least **ONE** proteasome inhibitor or the member has a contraindication to **ALL** proteasome inhibitors (e.g., bortezomib, Velcade (bortezomib), Kyprolis (carfilzomib), and Ninlaro (ixazomib))
7. Member's disease is refractory to at least **ONE** immunomodulatory agent or the member has a contraindication to **ALL** immunomodulatory agents (e.g., Pomalyst (pomalidomide), Revlimid (lenalidomide) and Thalomid (thalidomide))
8. Member's disease is refractory to at least **ONE** anti-CD38 monoclonal antibody or the member has a contraindication to **ALL** anti-CD38 monoclonal antibodies (Darzalex (daratumumab), Darzalex Faspro (daratumumabhyaluronidase-fihj), and Sarclisa (isatuximab-irfc))
9. 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. Elrexfio [package insert]. New York (NY): Pfizer Inc.; 2023 Aug.

Review History
04/10/24 – Created for P&T. Adopted MH criteria for Elrexfio 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