Mass General Brigham
Health Plan

T-Cell Lymphoma Agents
Beleodaq (belinostat)
Istodax (romidepsin lyophilized)
Lymphir (denileukin diftitox-cxdl)
Poteligeo (mogamulizumab-kpkc)
romidepsin (non- lyophilized)
Effective 01/04/2027

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 Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	N/A		

Overview
Beleodaq is a histone deacetylase inhibitor indicated for the treatment of patients with relapsed or refractory peripheral T-cell lymphoma (PTCL).

Lymphir (denileukin diftitox-cxdl) is an interleukin 2 (IL2)-receptor-directed cytotoxin indicated for the treatment of adult patients with relapsed or refractory (R/R) stage I-III CTCL after at least one prior line of systemic therapy.

Istodax (romidepsin) is a histone deacetylase (HDAC) inhibitor indicated for the treatment of cutaneous T-cell lymphoma (CTCL) in patients who have received at least one prior systemic therapy.

Poteligeo is a humanized monoclonal antibody that is directed against CC chemokine receptor type 4 (CCR4), which is frequently expressed on leukemic cells of certain hematologic malignancies. It is indicated for the treatment of two types of CTCL, mycosis fungoides and Sézary syndrome.

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 when all of the following criteria are met:

Istodax (romidepsin lyophilized)
Romidepsin (non-lyophilized)
1. Diagnosis of cutaneous T-cell lymphoma (CTCL)
2. Prescriber is an oncologist, hematologist, or dermatologist
3. Appropriate dosing (current weight and height required)

Poteligeo (mogamulizumab)

1. Diagnosis of ONE of the following:
    a. Sézary syndrome
    b. Stage IB to IV Mycosis fungoides
2. Prescriber is an oncologist or hematologist
3. Appropriate dosing

Beleodaq (belinostat)

1. Diagnosis of peripheral T-cell lymphoma
2. Prescriber is an oncologist or hematologist
3. Relapsed or refractory disease
4. Inadequate response or adverse reaction to ONE or contraindication to ALL second line treatment options *(refer to the latest NCCN guideline)*
5. Appropriate dosing

Lymphir (denileukin diftitox-cxdl)

1. Diagnosis of relapsed or refractory (R/R) stage I-III cutaneous T-cell lymphoma (CTCL)
2. Prescriber is an oncologist or hematologist
3. Inadequate response or adverse reaction to at least ONE prior line of systemic therapy *(refer to the latest NCCN guideline)*
4. Appropriate dosing

Off-Label Indications

Istodax (romidepsin lyophilized)
Romidepsin (non-lyophilized)

1. Diagnosis of peripheral T-cell lymphoma
2. Prescriber is an oncologist or hematologist
3. Inadequate response or adverse reaction to **ONE** or contraindication to **ALL** second line treatment options *(refer to the latest NCCN guideline)*
4. Appropriate dosing

Continuation of Therapy

Reauthorization by physician will infer a positive response to therapy.

Limitations

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

References

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4. Poteligeo [package insert on the internet]. Bedminster (NJ): Kyowa Kirin, Inc.; 2025 Mar.

5. Poteligeo Approved for 2 Rare Types of Non-Hodgkin Lymphoma [press release on the internet]. Tokyo, Japan: Kyowa Kirin; 2018 Aug 09 [cited 2022 Jul 11]. Available from: http://www.kyowa-kirin.com/news_releases/2018/e20180809_01.html.
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Review History

02/08/2023 - Reviewed and created for Feb P&T; Matched MH UPPL criteria to be in compliance with Masshealth unified formulary requirements. Effective 4/1/23.

05/15/2025 – Reviewed and updated for P&T. Performed annual medical criteria review. Policy has been updated to better reflect agents with prior authorization on medical benefit. Updated formatting and references. Removed required trial of generic equivalent per Brand Name guideline as it is not applicable to medical benefit. Effective 6/1/25
07/15/26 – Reviewed and updated for P&T. Added Lymphir injection to MB only. Effective 8/10/26
11/4/26 – Reviewed and updated for P&T. Criteria updates were made to Beleodaq and Poteligeo to better define place in therapy such as defining if disease is relapsed or refractory for Beleodaq and whether mycosis fungoides is stage IB to IV for Poteligeo. Initial approval duration was updated from 2 to 6 months. Effective 1/4/27