Utilization Review Policy 246A

POLICY: Oncology (Injectable – CAR-T) – Breyanzi Utilization Management Medical Policy

- Breyanzi® (lisocabtagene maraleucel suspension for intravenous infusion – Bristol-Myers Squibb)

EFFECTIVE DATE: 06/01/2021
LAST REVISION DATE: 01/17/2024

COVERAGE CRITERIA FOR: UCare Medicaid and Exchange Plans Only (PMAP, Connect, MSC+, MnCare, all Individual and Family Plans)

OVERVIEW

Breyanzi, a CD19-directed genetically modified autologous T-cell immunotherapy, is indicated for the treatment of **large B-cell lymphoma** (LBCL) including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from indolent lymphoma), high-grade B-cell lymphoma, primary mediastinal large B-cell lymphoma, and follicular lymphoma grade 3B, in adults who have:[1]

- Refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy.
- Refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplantation due to age or comorbidities.
- Relapsed or refractory disease after ≥ 2 lines of systemic therapy.

Limitations of use: Breyanzi is not indicated for the treatment of patients with primary central nervous system lymphoma.[1]

Dosing Information

Breyanzi is supplied in separate frozen vials containing the CD8 component and the CD4 component.[1] Each component is supplied in cartons containing one to four vials depending on the concentration of the cryopreserved chimeric antigen receptor (CAR)-positive T-cells. The vials are stored in the vapor phase of liquid nitrogen ≤ -130°C). The dose of Breyanzi for relapsed or refractory LBCL after ≥ 2 lines of therapy is 50 to 110 x 10^6 CAR-positive viable T cells (consisting of a 1:1 mixture of the CD8 and CD4 components), with each component supplied separately in single-dose vials. The dose for relapsed or refractory LBCL after one line of therapy is 90 to 110 x 10^6 CAR-positive viable T cells (consisting of a 1:1 mixture of the CD8 and CD4 components).

Guidelines

The National Comprehensive Cancer Network (NCCN) clinical practice guidelines address Breyanzi:

- **B-Cell Lymphomas** (version 6.2023 – October 10, 2023) guidelines recommend Breyanzi for the treatment of a variety of lymphomas.[2,3] Breyanzi can be used as second-line and subsequent therapy for relapsed or refractory DLBCL, high-grade B-cell lymphoma, human immunodeficiency virus (HIV)-related B-cell lymphoma, and post-transplant lymphoproliferative disorders. Breyanzi can also be used as third-line and subsequent therapy for transformed indolent lymphoma to DLBCL.
- **Pediatric Aggressive Mature B-Cell Lymphomas** (version 1.2023 – April 4, 2023) guidelines recommend Breyanzi for consolidation/additional therapy if the patient has achieved a partial response after treatment for relapsed/refractory primary mediastinal large B-cell lymphoma.[3,4] NCCN states this recommendation is based on extrapolation of results from clinical trials in adults with relapsed/refractory DLBCL including primary mediastinal large B-cell lymphoma.

Safety

Breyanzi has a Boxed Warning regarding cytokine release syndrome (CRS) and neurologic toxicities.[1] Breyanzi is only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Breyanzi REMS.

POLICY STATEMENT

Prior Authorization is recommended for medical benefit coverage of Breyanzi. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indication. Because of the specialized skills required for evaluation and diagnosis of patients treated with Breyanzi as well as the monitoring required for adverse events and long-term efficacy, approval requires Breyanzi to be prescribed by or in consultation with a physician who specializes in the condition being treated. The approval duration is 6 months to allow for an adequate time frame to prepare and administer 1 dose of therapy.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Breyanzi is recommended in those who meet the following criteria:

FDA-Approved Indication

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1. B-Cell Lymphoma. Approve a single dose if the patient meets ALL of the following (A, B, C, D, and E):

- **A)** Patient is ≥ 18 years of age; AND
- **B)** Patient meets ONE of the following (i or ii):
  - **i.** Patient meets BOTH of the following (a and b):
    - **a)** Patient has ONE of the following diagnoses [(1), (2), (3), (4), (5), (6), (7), (8), or (9)]:
      - **(1)** Large B-cell lymphoma; OR
      - **(2)** Diffuse large B-cell lymphoma; OR
      - **(3)** High-grade B-cell lymphoma; OR
      - **(4)** Primary mediastinal large B-cell lymphoma; OR
      - **(5)** Follicular lymphoma, Grade 3B; OR
      - **(6)** Human immunodeficiency virus (HIV)-related diffuse large B-cell lymphoma; OR
      - **(7)** Human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma; OR
      - **(8)** Primary effusion lymphoma; OR
      - **(9)** Post-transplant lymphoproliferative disorders; AND
    - **b)** Patient has received at least one line of systemic therapy; OR
  - **ii.** Patient meets BOTH of the following (a and b):
    - **a)** Patient has transformed indolent lymphoma to diffuse large B-cell lymphoma; AND
    - **b)** Patient has received at least two lines of systemic therapy; AND
- **C)** Patient has received or plan to receive lymphodepleting chemotherapy prior to infusion of Breyanzi; AND
- **D)** Patient has not been previously treated with CAR-T therapy; AND
  Note: Examples of CAR-T therapy includes Breyanzi, Kymriah (tisagenlecleucel intravenous infusion), Tecartus (brexucabtagene intravenous infusion), and Yescarta (axicabtagene intravenous infusion).
- **E)** The medication is prescribed by or in consultation with an oncologist.

Dosing. The dose is 50 to 110 x 10^6 CAR-positive viable T-cells administered intravenously as a single dose.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Breyanzi is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Breyanzi® intravenous infusion [prescribing information]. Bothell, WA: Juno Therapeutics; June 2023.
2. The NCCN B-Cell Lymphoma Clinical Practice Guidelines in Oncology (version 6.2023 – October 10, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed January 8, 2024.
3. The NCCN Drugs and Biologics Compendium. © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on January 8, 2024. Search term: lisocabtagene.
4. The NCCN Pediatric Aggressive Mature B-Cell Lymphomas Clinical Practice Guidelines in Oncology (version 1.2023 – April 4, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed January 8, 2024.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	01/18/2023
Annual Revision	**B-Cell Lymphoma:** Revised acquired immunodeficiency syndrome (AIDS) to human immunodeficiency virus (HIV).	01/17/2024