Axicabtagene Ciloleucel (Yescarta®)

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

The proposal is to add text/statements in red and to delete text/statements with strikethrough:

POLICY

INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

- Adult patients with large B-cell lymphoma that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy.
- Adult patients with relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (NOS), primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, and DLBCL arising from follicular lymphoma.
- Adult patients with relapsed or refractory follicular lymphoma (FL) after two or more lines of systemic therapy.

Limitations of Use:
Yescarta is not indicated for the treatment of patients with primary central nervous system lymphoma.

Compendial Uses

- Histologic transformation of indolent lymphomas to DLBCL
- Human immunodeficiency virus (HIV)-related B-cell lymphomas ~~(including HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus 8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specific)~~
- Monomorphic post-transplant lymphoproliferative disorder (B-cell type)
- Marginal zone lymphomas (MZL):
  - Extranodal MZL of the stomach (gastric mucosa associated lymphoid tissue (MALT) lymphoma)
  - Extranodal MZL of nongastric sites (nongastric MALT lymphoma)
  - Nodal MZL
  - Splenic MZL
- Pediatric primary mediastinal large B-cell lymphoma

All other indications are considered experimental/investigational and not medically necessary.

DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:

Chart notes or medical record documentation demonstrating failure of ~~or claims history supporting~~ previous lines of therapy.

EXCLUSIONS

Coverage will not be provided for members with any of the following exclusions:

- Primary central nervous system lymphoma
- Previous treatment course with the requested medication or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy.
- ECOG performance status greater than or equal to 3 (member is not ambulatory and not capable of all self-care, confined to bed or chair more than 50% of waking hours)
- Inadequate and unstable kidney, liver, pulmonary or cardiac function
- Active hepatitis B, active hepatitis C or a clinically significant active systemic infection
- Active inflammatory disorder

CRITERIA FOR INITIAL APPROVAL

Adult Large B-cell Lymphomas

Authorization of 3 months (one dose) may be granted as treatment of B-cell lymphomas in members 18 years of age or older when either of the following criteria are met:

- The member has received prior treatment with two or more lines of systemic therapy and has any of the following B-cell lymphoma subtypes:
  - Diffuse large B-cell lymphoma (DLBCL) arising from follicular lymphoma
  - Histologic transformation of indolent lymphomas to DLBCL
  - Diffuse large B-cell lymphoma (DLBCL)
  - Primary mediastinal large B-cell lymphoma
  - High-grade B-cell lymphomas (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified)
  - Human immunodeficiency virus (HIV)-related B-cell lymphomas (including HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, ~~and~~ human herpesvirus 8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specific, and plasmablastic lymphoma)
  - Monomorphic post-transplant lymphoproliferative disorder (B-cell type)
  - Follicular lymphoma
  - Extranodal marginal zone lymphoma of the stomach (gastric MALT)
  - Extranodal marginal zone lymphoma of nongastric sites (nongastric MALT)
  - Nodal marginal zone lymphoma
  - Splenic marginal zone lymphoma
- The member has received prior treatment with first-line chemoimmunotherapy and has relapsed/refractory disease with any of the following B-cell lymphoma subtypes:
  - Diffuse large B-cell lymphoma (DLBCL)
  - Primary mediastinal large B-cell lymphoma
  - High-grade B-cell lymphomas (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified)
  - Human immunodeficiency virus (HIV)-related B-cell lymphomas (including HIV -related diffuse large B-cell lymphoma, primary effusion lymphoma, ~~and~~ human herpesvirus 8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specific, and plasmablastic lymphoma)
  - Monomorphic post-transplant lymphoproliferative disorder (B-cell type)

Pediatric Primary Mediastinal Large B-cell Lymphoma

Authorization of 3 months (one dose) may be granted for treatment of relapsed/refractory primary mediastinal large B-cell lymphoma in members less than 18 years of age when the member has received prior therapy with at least two prior chemoimmunotherapy regimens and achieved partial response.

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

REFERENCES

1. Yescarta [package insert]. Santa Monica, CA: Kite Pharma; June 2024.
2. The NCCN Drugs & Biologics Compendium® © 2025 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed April 29, 2025.
3. The NCCN Clinical Practice Guidelines in Oncology® B-Cell Lymphomas (Version 2.2025). © 2025 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed April 29, 2025.
4. Neelapu SS, Locke FL, Bartlett NL, et al. Axicabtagene Ciloleucel CAR T-Cell Therapy in Refractory Large B-Cell Lymphoma. N Engl J Med. 2017;377(26):2531-2544.
5. Clinical Consult: CVS Caremark Clinical Programs Review. Focus on Hematology-Oncology Clinical Programs. September 2021.

EFFECTIVE DATE

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