Inotuzumab Ozogamicin (Besponsa™)

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.

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

Besponsa is indicated for the treatment of relapsed or refractory CD22-positive B-cell precursor acute lymphoblastic leukemia (ALL) in adult and pediatric patients 1 year and older. .

Compendial Use

- Pediatric acute lymphoblastic leukemia (ALL)
- ALL- frontline/consolidation therapy
- Lymphoblastic Lymphoma

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

DOCUMENTATION

Submission of testing or analysis confirming CD22 protein on the surface of the B-cell is necessary to initiate the prior authorization review for applicable indications as outlined in the coverage criteria section.

COVERAGE CRITERIA

Acute Lymphoblastic Leukemia (ALL) / Lymphoblastic Lymphoma

Authorization of 12 months may be granted for treatment of ALL/ lymphoblastic lymphoma as frontline (induction / consolidation) therapy when all of the following criteria are met:

- Member has B-cell precursor ALL/ lymphoblastic lymphoma.
- The tumor is CD22-positive as confirmed by testing or analysis to identify the CD22 protein on the surface of the B-cell.
- Member has Philadelphia chromosome-negative disease.
- The requested medication will be used in combination with mini-hyper-CVD (mini-hyperfractionated cyclophosphamide, vincristine, dexamethasone, methotrexate and cytarabine) with or without blinatumomab.
- Member will not receive more than 6 treatment cycles of the requested medication.

Authorization of 12 months may be granted for treatment of relapsed or refractory ALL/ lymphoblastic lymphoma when all of the following criteria are met:

- Member has B-cell precursor ALL / lymphoblastic lymphoma.
- The tumor is CD22-positive as confirmed by testing or analysis to identify the CD22 protein on the surface of the B-cell.
- Member meets one of the following criteria:
  - Member has Philadelphia chromosome-positive disease.
  - Member has Philadelphia chromosome-negative disease.
- Member meets one of the following criteria:
  - The requested medication will be used as a single agent.
    - The requested medication will be used in combination with a tyrosine kinase inhibitor for Philadelphia chromosome-positive disease (e.g., imatinib, dasatinib, nilotinib, bosutinib, ponatinib).
    - The requested medication will be used in combination with mini-hyper-CVD (mini-hyperfractionated cyclophosphamide, vincristine, dexamethasone, methotrexate, and cytarabine) with or without blinatumomab.
- Member will not receive more than 6 treatment cycles of the requested medication.

CONTINUATION OF THERAPY

Authorization of 12 months (up to 6 cycles total) may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

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. Besponsa [package insert]. Philadelphia, PA: Wyeth Pharmaceuticals LLC, Inc.; March 2024.
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3. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Pediatric Acute Lymphoblastic Leukemia. Version 3.2025.Available at: https://nccn.org. Accessed June 12, 2025.
4. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Acute Lymphoblastic Leukemia. Version 2.2025.Available at: https://nccn.org. Accessed September 29, 2025.

BlueCross BlueShield of Tennessee

Policy

Medical Policy Manual **Approved Rev: Do Not Implement until 4/2/26**

EFFECTIVE DATE 4/2/2026

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