Levoleucovorin (Khapzory®), Levoleucovorin

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

- Levoleucovorin/Fusilev/Khapzory is indicated for rescue after high-dose methotrexate therapy in adults and pediatric patients with osteosarcoma.
- Levoleucovorin/Fusilev/Khapzory is indicated for diminishing the toxicity associated with overdosage of folic acid antagonists or impaired methotrexate elimination in adult and pediatric patients.
- Levoleucovorin/Fusilev/Khapzory is indicated for the treatment of adults with metastatic colorectal cancer in combination with fluorouracil.

Compendial Uses

- Rescue treatment after high-dose methotrexate therapy
- Combination with fluorouracil-based chemotherapy regimens

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

COVERAGE CRITERIA

Authorization of 3 months may be granted for any of the settings listed below when leucovorin is not an appropriate/available option at this time:

- Rescue treatment after high-dose methotrexate therapy
- Treatment of a folate antagonist overdose or impaired methotrexate elimination
- Combination therapy with fluorouracil-based chemotherapy regimens

CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all requirements in the coverage criteria.

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. Levoleucovorin injection [package insert]. Chicago, IL; Meitheal Pharmaceuticals; December 2020.
2. Khapzory [package insert]. East Windsor, NJ: Acrotech Biopharma Inc.; December 2024.
3. The NCCN Drugs & Biologics Compendium® © 2025 National Comprehensive Cancer Network, Inc. Available at: https://www.nccn.org . Accessed July 21, 2025.

EFFECTIVE DATE 4/2/2026

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