Teclistamab-cqyv (Tecvayli™)

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
Tecvayli is indicated for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least four prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent and an anti-CD38 monoclonal antibody.

Compendial Use
- Multiple myeloma
- POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome
- Monoclonal immunoglobulin deposition disease (MIDD)
- Plasma cell-related monoclonal gammopathy of renal significance (MGRS)

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 previous lines of therapy.

COVERAGE CRITERIA

Multiple Myeloma

Authorization of 12 months may be granted for treatment of relapsed or refractory multiple myeloma when any of the following criteria is met:
- The requested medication will be used in combination with daratumumab (Darzalex) or daratumumab and hyaluronidase-fihj (Darzalex Faspro) and member is bortezomib- refractory or lenalidomide-refractory.
- The requested medication will be used as a single agent and member has received at least 4 prior therapies, including at least one drug from each of the following categories:
  - Proteasome inhibitor (e.g., bortezomib, ixazomib, carfilzomib)
  - Immunomodulatory agent (e.g., lenalidomide, pomalidomide, thalidomide)
  - Anti-CD38 monoclonal antibody (e.g., daratumumab, isatuximab)

- The requested medication will be used in combination with talquetamab-tgvs (Talvey) and member has received at least 3 prior therapies

POEMS (Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal protein, Skin changes) Syndrome, Monoclonal Immunoglobulin Deposition Disease (MIDD), and Monoclonal Gammopathy of Renal Significance (MGRS)

Authorization of 12 months may be granted for the treatment of POEMS syndrome, MIDD, and plasma cell-related MGRS as a single agent or in combination with daratumumab (Darzalex), daratumumab and hyaluronidase-fihj (Darzalex Faspro) or talquetamab-tgvs (Talvey).

CONTINUATION OF THERAPY

Authorization of 12 months 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. Tecvayli [package insert]. Horsham, PA: Janssen Biotech, Inc.; February 2024.
2. The NCCN Drugs & Biologics Compendium® © 2026 National Comprehensive Cancer Network, Inc. Available at: https://www.nccn.org. Accessed February 3, 2026.

EFFECTIVE DATE 7/31/2026

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