

## Medical Policy Manual **Approved New: Do Not Implement until 12/31/25**

### **Linvoseltamab-gcpt (Lynozytic™)**

#### **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 Indication

Lynozytic 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.

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 the 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)

#### **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**

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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. Lyozyfic [package insert]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.; July 2025.

**EFFECTIVE DATE**      12/31/2025

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