Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines
Medical Benefit Drugs

Breyanzi® (lisocabtagene maraleucel)

Effective: September 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	Yes ☒ No ☐

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax 617-673-0988
☒ Tufts Health Plan Commercial products; Fax 617-673-0988

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 617-673-0988
☐ Tufts Health Together – MassHealth Accountable Care Partnership Plans; Fax 617-673-0939
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 617-673-0939
☐ Tufts Health One Care-- A dual-eligible product; Fax 617-673-0956

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0956
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0956
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0956

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Chimeric antigen receptor T-cell therapy (CAR-T cell therapy), a type of immunotherapy which may also be referred to as adoptive T-cell therapy, attempts to program patients' own immune systems to recognize and attack cancer cells. The first step in this therapy is to remove T-cells from the patient via apheresis, a process that removes blood from the body and removes one or more blood components (such as white blood cells, plasma, or platelets). The remaining blood is then returned to the body. The T-cells are then sent to a drug manufacturing facility or laboratory where they are genetically engineered to produce chimeric antigen receptors (CARs) on their surface. These CARs are what allow the T-cells to recognize an antigen on targeted tumor cells. The genetically modified T-cells are grown in the lab until there are enough of them (many millions) to freeze and return to the center treating the patient. There they are infused into the recipient with the expectation that the CAR T cells will recognize and kill cancerous cells that have the targeted antigen on their surface. Since the CAR-T cells may remain in the body long after the infusion, it is possible the treatment can bring about long-term remission. CAR-T cell therapy can be used to treat certain hematologic malignancies when the disease is relapsed or refractory to standard line(s) of treatment.

Food and Drug Administration (FDA) Approved Indications:

BREYANZI (lisocabtagene maraleucel) is a CD19-directed genetically modified autologous T cell immunotherapy indicated for the treatment of:

- Adult patients with large B-cell lymphoma (LBCL), including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from indolent lymphoma), high-grade B-cell lymphoma, primary mediastinal large B-cell lymphoma, and follicular lymphoma who have:
  - Refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy; or
  - Refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplantation (HSCT) due to comorbidities or age; or
  - Relapsed or refractory disease after two or more lines of systemic therapy.
- Adult patients with relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) who have:

- Received at least 2 prior lines of therapy, including a Bruton tyrosine kinase (BTK) inhibitor and a B-cell lymphoma 2 (BCL-2) inhibitor.

- Adult patients with relapsed or refractory mantle cell lymphoma (MCL) who have received at least 2 prior lines of systemic therapy, including a Bruton tyrosine kinase (BTK) inhibitor.
- Adult patients with relapsed or refractory marginal zone lymphoma (MZL) who have received at least 2 prior lines of systemic therapy or failed HSCT.

Breyanzi is not indicated for the treatment of patients with primary central nervous system lymphoma.

- **NOTE**: According to recent updated guidance from the FDA, the REMS Program requirement is no longer required.[1]
- **NOTE**: Tocilizumab must be available to treat potential serious adverse reactions as needed.

Clinical Guideline Coverage Criteria

The Plan may cover Breyanzi when **all** of the following clinical criteria are met:

For Pediatric Aggressive Mature B-cell Lymphomas

1. The Member is under 18 years of age, and has been diagnosed with primary mediastinal large B-cell lymphoma and has failed, had suboptimal response or contraindication to a minimum of two lines of chemoimmunotherapy regimens[25]

For Large B-cell lymphoma

1. The Member is age 18 years of age or older and has been diagnosed with large B-cell lymphoma (LBCL), including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from indolent lymphoma), high-grade B-cell lymphoma, primary mediastinal large B-cell lymphoma, and follicular lymphoma

AND

2. Who have **one** of the following:
   a. Refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy
   b. Refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplantation (HSCT) due to comorbidities or age
   c. Relapsed or refractory disease after two or more lines of systemic therapy

   * Relapsed/Refractory defined as disease progression after the last treatment regimen or refractory/suboptimal response to the most recent therapy

AND

3. Member's previous treatments, unless contraindicated, must have included but are not limited to **all** of the following drug therapies:
   a. A CD20-targeted agent (e.g., rituximab)

   AND

   b. Anthracycline-based chemotherapy (e.g., doxorubicin, epirubicin)

AND

4. The Member has an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2

For Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic lymphoma (SLL)

1. The Member is age 18 years of age or older and has been diagnosed with relapsed or refractory CLL or SLL

AND

2. The Member has received two prior lines of therapy including a Burton tyrosine kinase (BTK) inhibitor (e.g. acalabrutinib, ibrutinib, zanubrutinib) and a B-cell lymphoma 2 (BCL-2) inhibitor (e.g. venetoclax).

AND

3. The Member has an Eastern Cooperative Oncology Group (ECOG) performance status 0 to 1.

For Mantle Cell Lymphoma (MCL):

1. The Member is age 18 years of age or older and has been diagnosed with relapsed or refractory MCL.

AND

2. The Member has received two or more lines of systemic therapy including a Burton tyrosine kinase (BTK) inhibitor (e.g. acalabrutinib, ibrutinib, zanubrutinib)

AND

3. The Member has an Eastern Cooperative Oncology Group (ECOG) performance status 0 to 1.

For Marginal Zone Lymphoma (MZL):

1. The Member is age 18 years of age or older and has been diagnosed with relapsed or refractory MZL.

AND

2. The Member has received two or more lines of systemic therapy including one alkylating agent and one anti-CD20 agent;

AND

3. The Member has an Eastern Cooperative Oncology Group (ECOG) performance status 0 to 1.

OR

1. The Member has relapsed after hematopoietic stem cell transplant.

For all indications:

1. The Member does not have primary central nervous system (CNS) lymphoma

AND

2. The Member has adequate organ function including bone marrow, cardiac, pulmonary, and neurological with no anticipated decline in organ function in close proximity to apheresis timeframe

AND

3. The Member does not have untreated active systemic infection or uncontrolled inflammatory condition.

AND

4. For Members with a history of allogeneic stem cell transplantation, there is no indication of active graft vs. host disease (GVHD).

NOTE: Documentation submitted must list previous lines of treatment/systemic therapies and date of each therapy

In addition to the above criteria, the Plan may cover Breyanzi in an outpatient setting when the provider attests that they have assessed the Member and determined that outpatient administration is clinically appropriate.

NOTE: Prior authorization for Breyanzi is required regardless of hospital inpatient or outpatient setting.

Limitations

- Breyanzi therapy is contraindicated in pregnancy.
- Members receiving immunosuppressive therapy that is likely (high risk) to interfere with T cell function will not be approved for Breyanzi therapy.
- Members with untreated underlying primary immunodeficiency syndromes will not be approved for Breyanzi therapy.
- Members with active and/or metastatic malignancy that is unlikely to respond to treatment will not be approved for Breyanzi therapy.
- Authorization of Breyanzi therapy is limited to a single dose.
- Members who have had prior treatment with any form of CAR-T cell therapy, including therapies in clinical trial settings, will not be approved for additional CAR-T therapy.
- Breyanzi therapy will not be covered if the Member demonstrates clinical decompensation from time of authorization to time of infusion and no longer meets clinical coverage criteria.
- Any indications for Breyanzi therapy other than those outlined above are considered investigational and will not be covered

ECOG Performance Status:

- 0: Fully active, no restrictions on activities. A performance status of 0 means no restrictions in the sense that someone is able to do *everything* they were able to do prior to their diagnosis.
- 1: Unable to do strenuous activities, but able to carry out light housework and sedentary activities. This status basically means you can't do heavy work but can do anything else.
- 2: Able to walk and manage self-care, but unable to work. Out of bed more than 50% of waking hours. In this category, people are usually unable to carry on any work activities, including light office work.
- 3: Confined to bed or a chair more than 50 percent of waking hours. Capable of limited self-care.
- 4: Completely disabled. Totally confined to a bed or chair. Unable to do any self-care.
- 5: Death

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-CD19 CAR-positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic doses

References:

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Approval And Revision History

September 21, 2022: Reviewed by the Medical Policy Approval Committee (MPAC)

Subsequent endorsement date(s) and changes made:

- Originally approved at September 21, 2022 MPAC effective January 1, 2023
- Administrative update: November 2023 added Medical Benefit Drugs to title, updated MATogether and RITogether fax numbers to 617-673-0939, and change Unify name to One Care effective January 1, 2024
- October 18, 2023: Reviewed by MPAC, renewed without changes effective January 1, 2024
- January 2024: added language to allow for contraindication to previous treatment, updated organ function criteria question, added criteria for allow for outpatient administration, updated ECOG from 0-1 to 0-2, removed history of CNS disease limitation, and updated references effective March 1, 2024
- April 17, 2024: Reviewed at Medical Policy Approval Committee Added Indication for relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) effective June 1, 2024.
- July 22, 2024 Reviewed by MPAC added Mantle Cell Lymphoma indication and opened up to all Follicular Lymphoma, not just Follicular Lymphoma grade 3B effective September 1, 2024.

- November 21, 2024: Reviewed by MPAC, updated criteria to specify untreated active systemic infection effective January 1, 2025.
- December 18, 2024: Renewed by MPAC. Coding updated: Removal of prior authorization from 0537T, 0538T, 0539T, and 0540T. Effective January 1, 2025.
- February 19, 2025: Reviewed by MPAC; Removed Richter's transformation limitation. References updated. Effective April 1, 2025.
- June 18, 2025: Reviewed by MPAC. Annual review.
- July 16, 2025: Reviewed by MPAC. REMS language removed from both Overview and Criteria sections. Two notes were added in the Overview section. Added Pediatric Aggressive Mature B-cell Lymphomas criteria. Refined the limitation regarding immunosuppressive therapy to specify high risk to interfere with T cell function. References updated. Effective date September 1, 2025.
- August 7, 2025: Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template.
- February 18, 2026: Reviewed by MPAC. Added Marginal Zone Lymphoma criteria to align with FDA label expansion. References updated. Effective date April 1, 2026.
- July 15, 2026: Reviewed by MPAC. Annual Review. References updated. Effective September 1, 2026.

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.