Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines
Medical Benefit Drugs
Kymriah® (tisagenlecleucel)

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:

Kymriah (tisagenlecleucel) is FDA-Approved for the following indication(s):

Pediatric and Young Adult Relapsed or Refractory (r/r) B-cell Acute Lymphoblastic Leukemia (ALL).

- Kymriah is indicated for the treatment of patients up to 25 years of age with B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse.
- Adult Relapsed or Refractory (r/r) Diffuse Large B-cell Lymphoma (DLBCL) Adult patients with relapsed or refractory (r/r) large B-cell lymphoma after two or more lines of systemic therapy including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (NOS), high grade B-cell lymphoma and DLBCL arising from follicular lymphoma.

KYMRIAH 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 authorize Kymriah when **All** of the following clinical criteria are met:

1. The Member is 25 years of age or younger, has been diagnosed with CD19-positive B- cell precursor acute lymphoblastic leukemia (ALL), and has failed, had suboptimal response, or contraindication to a minimum of two lines of treatment.

OR

2. The Member is 25 years of age or younger, has been diagnosed with B-cell precursor acute lymphoblastic leukemia (ALL), and is experiencing a second or later relapse (defined as the reappearance of leukemic lymphoblasts in peripheral blood or bone marrow after there has been achievement of complete remission with other lines of treatment) after a minimum of two lines of treatment or contraindication to all lines of treatment.

OR

3. The Member is 18 years of age or older, has been diagnosed with CD19-positive large B-cell lymphoma, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, high grade B-cell lymphoma, and DLBCL arising from follicular lymphoma, and has failed, had suboptimal response or contraindication to a minimum of two lines of systemic therapy.

OR

4. The Member is 18 years of age or older, has been diagnosed with large B-cell lymphoma, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, high grade B-cell lymphoma, and DLBCL arising from follicular lymphoma, and is experiencing a biopsy proven relapse (defined as biopsy proven return of DLBCL disease after achievement of complete remission with other lines of treatment) after treatment or contraindication with a minimum of two lines of systemic therapy.

AND

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

AND

6. The Member has had no prior treatment with CAR-T therapy.

AND

7. 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

8. The member does not have an untreated active systemic infection or uncontrolled inflammatory disorder.

AND

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

AND

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

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 Kymriah 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 Kymriah is required regardless of hospital inpatient or outpatient setting.

Limitations

- Kymriah 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 Kymriah therapy.
- Members with untreated underlying primary immunodeficiency syndromes will not be approved for Kymriah therapy.
- Members with active and/or metastatic malignancy that is unlikely to respond to treatment will not be approved for Kymriah therapy.
- Authorization of Kymriah 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.

- Kymriah 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 Kymriah CAR T-cell 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: CPT Codes

CPT Codes	Description
	none

Table 2: HCPCS Codes

HCPCS Codes	Description
Q2042	Tisagenlecleucel, up to 600 million CAR-positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic dose

References:

1. FDA Eliminates Risk Evaluation and Mitigation Strategies (REMS) for Autologous Chimeric Antigen Receptor (CAR) T cell Immunotherapies. https://www.fda.gov/vaccines-blood-biologics/safety-availability-biologics/fda-eliminates-risk-evaluation-and-mitigation-strategies-rems-autologous-chimeric-antigen-receptor. Published June 26, 2025. Accessed June 26, 2025.
2. Center for Medicare and Medicaid National Coverage Determination (NCD) for Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) last accessed June 28, 2021 at NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) (cms.gov)
3. Relapsed or refractory diffuse large B cell lymphoma. UpToDate.com/login [via subscription only]. Accessed July 2, 2025.
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5. Hansen, D. K., Liu, Y. H., Ranjan, S., Bhandari, H., Potluri, R., McFarland, L., De Braganca, K. C., & Huo, S. (2023). The Impact of Outpatient versus Inpatient Administration of CAR-T Therapies on Clinical, Economic, and Humanistic Outcomes in Patients with Hematological Cancer: A Systematic Literature Review. Cancers, 15(24), 5746. https://doi.org/10.3390/cancers15245746
6. National Comprehensive Cancer Network. Acute Lymphoblastic Leukemia (Version 1.2026). April 8, 2026. Available at: nccn.org/professionals/physician_gls/pdf/all.pdf. Accessed May 5, 2026.
7. Leukemia and Lymphoma Society. Minimal Residual Disease. No. 35 in a series providing the latest information for patients, caregivers, and healthcare professionals. lls.org/sites/default/files/National/USA/Pdf/Publications/FS35_MRD_Final_2019.pdf accessed November 19, 2021.
8. Leukemia & Lymphoma Society. Chimeric Antigen Receptor (CAR) T-Cell Therapy Facts. Available at lls.org. Last accessed October 20, 2017
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11. United States Food and Drug Administration. Package Insert-KYMRIAH. Available at fda.gov. September 2021.
12. United States Department of Health and Human Services, National Institutes of Health, National Cancer Institute. CAR-T Cells: Engineering Patients' Immune Cells to Treat Their Cancers. Available at cancer.gov. Last accessed October 24, 2017.
13. Schrappe M. Detection and management of minimal residual disease in acute lymphoblastic leukemia. Hematology Am Soc Hematol Educ Program. 2014;2014(1):244-249. doi:10.1182/asheducation- 2014.1.244.
14. Shah BD, Ghobadi A, Oluwole OO, et al. KTE-X19 for relapsed or refractory adult B-cell acute lymphoblastic leukemia: phase 2 results of the single-arm, open-label, multicenter ZUMA-3 study. Lancet. 2021;398(10299):491-502. doi:10.1016/S0140-6736(21)01222-8.
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16. Dreyling M, Fowler NH, Dickinson M, et al. Durable response after tisagenlecleucel in adults with relapsed/refractory follicular lymphoma: ELARA trial update. Blood. 2024;143(17):1713-1725. doi:10.1182/blood.2023021567
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20. National Comprehensive Cancer Network. Pediatric Acute Lymphoblastic (Version 1.2026). August 11, 2025. https://www.nccn.org/professionals/physician_gls/pdf/ped_all.pdf. Accessed May 5, 2026.
21. Treatment of relapsed or refractory acute lymphoblastic leukemia in adults. UpToDate.com/login [via subscription only]. Published March 3, 2025. Updated April 1, 2026. Accessed May 6, 2026
22. Relapsed or refractory acute lymphoblastic leukemia/lymphoblastic lymphoma in children and adolescents. .com/login [via subscription only]. Published August 22, 2025. Updated April 1, 2026. Accessed May 6, 2026
23. Ludwig H, et. al. Prevention and management of adverse events during treatment with bispecific antibodies and CAR T cells in multiple myeloma: a consensus report of the European Myeloma Network. Lancet Oncol. 2023 Jun;24(6):e255-e269. doi: 10.1016/S1470-2045(23)00159-6. PMID: 37269857.
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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
- November 16, 2023: Reviewed by MPAC, renewed without changes effective January 1, 2024
- January 17, 2024: Reviewed by MPAC, added language to allow for contraindication to previous treatments, updated organ function criteria question, added criteria for allow for outpatient administration, updated ECOG from 0-1 to 0-2, and updated references effective March 1, 2024
- November 21, 2024: Reviewed by MPAC, updated criteria to specify untreated active systemic infection, or uncontrolled inflammatory condition, effective January 1, 2025.
- December 18, 2024: Reviewed by MPAC; Coding updated: Removal of prior authorization from 0537T, 0538T, 0539T, and 0540T. Effective January 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. Refined the limitation regarding immunosuppressive therapy to specify high risk to interfere with T cell function. References were updated. Effective date September 1, 2025.

- 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.