Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines
Medical Benefit Drugs

Tecartus® (brexucabtagene autoleucel)

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:

TECARTUS (brexucabtagene autoleucel) is a CD19-directed genetically modified autologous T cell immunotherapy indicated for the treatment of:

- Adult patients with relapsed or refractory mantle cell lymphoma (MCL). This indication is approved under accelerated approval based on overall response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.
- Adult patients with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL)
- **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 Tecartus for the treatment of members aged 18 or over when **ALL** of the following are met:

1. The Member has been diagnosed with relapsed or refractory mantle cell lymphoma (MCL), defined as disease progression after last treatment regimen or refractory to the most recent therapy, as confirmed by circulating clonal lymphocytes, bone marrow involvement and/or measurable lymphadenopathy. This is defined as disease progression after last treatment regimen or refractory/suboptimal response to the most recent therapy.

AND

   a. The Member's previous treatments, unless contraindicated, must have included (but are not limited to) **ALL** of the following:
      a. Anthracycline or bendamustine-containing chemotherapy.
      b. Anti-CD20 monoclonal antibody therapy (e.g. rituximab)
      c. Bruton's tyrosine kinase inhibitor (BTKi) therapy (e.g. ibrutinib, acalabrutinib, zanubrutinib)

OR

   b. The Member has been diagnosed with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL).

AND

2. The Member is with morphological disease in the bone marrow (>5% blasts) **OR** is with minimal residual disease (MRD) positivity as documented by flow cytometry.

AND

3. The Member's disease is defined as **one** (1) of the following:
   a. Primary refractory ALL
   b. First relapse following a remission lasting 12 months or less.
   c. Relapsed or refractory ALL after **two** (2) or more lines of systemic therapy.
   d. Relapsed or refractory ALL following allogenic stem cell transplantation and there is no indication of active GVHD.

AND

4. If the Member has been diagnosed with Philadelphia chromosome-positive (Ph+) ALL, one (1) of the following is met:
   a. Member is intolerant to tyrosine kinase inhibitor (TKI) therapy.
   b. Member is with relapsed/refractory disease despite treatment which has included **two** (2) or more different TKI therapies (e.g. ponatinib, imatinib, dasatinib, nilotinib)

AND

5. If prior therapy includes a CD19 directed therapy (e.g. blinatumomab), CD19 tumor expression is demonstrated to be present in bone marrow or peripheral blood.

AND

6. 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

7. The Member does not have active hepatitis B, active hepatitis C, or any untreated active systemic infection.

AND

8. The Member does not have active graft versus host disease.

AND

9. The Member does not have an uncontrolled inflammatory disorder.

AND

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

AND

11. The Member has an Eastern Cooperative Oncology Group (ECOG) performance status of 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 Teacartus 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 Tecartus is required regardless of hospital inpatient or outpatient setting.

Limitations

- Tecartus therapy is contraindicated for use in pregnancy.
- Members receiving immunosuppressive therapy that is likely (high risk) to interfere with T cell function will not be approved for Tecartus.
- Members with untreated underlying primary immunodeficiency syndromes will not be approved for Tecartus therapy.
- Members with active and/or metastatic malignancy that is unlikely to respond to treatment will not be approved for Tecartus therapy.

- Authorization of Tecartus 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.
- Tecartus 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.
- Tecartus will not be approved for members with CNS-3 disease or CNS-2 disease with neurological changes (see reference below).
- Any indications for 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

CNS 1 disease was defined as the absence of leukemia in cerebrospinal fluid. CNS-2 disease was defined as detectable cerebrospinal blasts with less than five white blood cells per mm^3.)
CNS 2: WBC count of less than 5/mL and blasts on cytospin findings, or WBC count of more than 5/mL but negative by Steinherz-Bleyer algorithm findings (if traumatic tap).
CNS 3: WBC count of 5/mL or more and blasts on cytospin findings and/or clinical signs of CNS leukemia (e.g., facial nerve palsy, brain/eye involvement, hypothalamic syndrome

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti-CD19 CAR positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic dose

References:

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14. United States Food and Drug Administration. Package Insert-TECARTUS. Available at fda.gov. Last accessed March 17, 2022.
15. Wang M, Munoz J, Goy A, et al. KTE-X19 CAR T-Cell Therapy in Relapsed or Refractory Mantle-Cell Lymphoma. N Engl J Med. 2020;382(14):1331-1342. doi:10.1056/NEJMoa1914347.
16. Trando A, Ter-Zakarian A, Yeung P, et al. Outcomes of Chimeric Antigen Receptor (CAR) T-Cell Therapy in Patients with Large B-Cell Lymphoma (LBCL): A Single-Institution Experience. *Cancers (Basel)*. 2023;15(18):4671. Published 2023 Sep 21. doi:10.3390/cancers15184671
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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, renewed without changes effective January 1, 2024
- January 17, 2024: Reviewed by MPAC, 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, 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 added in the Overview section. Refined the limitation regarding immunosuppressive therapy to specify high risk to interfere with T cell function. References 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.