Medical Policy
Chimeric Antigen Receptor Therapy for Hematologic Malignancies

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Policy Number: 066
BCBSA Reference Number: 8.01.63
NCD/LCD: N/A

Related Policies
• Adoptive Immunotherapy, #455
• CAR T-Cell Therapy Services for the Treatment of Diffuse Large B-cell Lymphoma (axicabtagene cilleucel or tisagenlecleucel) Prior Authorization Request Form, #924
• CAR T-Cell Therapy Services for B-cell Acute Lymphoblastic Leukemia (tisagenlecleucel) Prior Authorization Request Form, #925
• Cellular Immunotherapy for Prostate Cancer, #268

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

Prior Authorization Request Form: Chimeric Antigen Receptor Therapy for Hematologic Malignancies
This form must be completed and faxed to: Medical and Surgical: 1-888-282-0780; Medicare Advantage: 1-800-447-2994.
• Click here for CAR T-Cell Therapy Services for the Treatment of Diffuse Large B-cell Lymphoma (axicabtagene cilleucel or tisagenlecleucel) Prior Authorization Request Form #924
• Click here for CAR T-Cell Therapy Services for B-cell Acute Lymphoblastic Leukemia (tisagenlecleucel) Prior Authorization Request Form #925

Tisagenlecleucel (Kymriah): B-cell acute lymphoblastic leukemia
Chimeric antigen receptor T-cell (CAR-T) therapy with tisagenlecleucel intravenous infusion may be considered MEDICALLY NECESSARY for relapseda (second or later) or refractoryb patients if they meet all of following criteria:
- Confirmed diagnosis of CD19-positive B-cell acute lymphoblastic leukemia with morphologic marrow tumor involvement (≥ 5% lymphoblasts)
- Are up to 25 years old at the time of infusion
- Have not received prior treatment with tisagenlecleucel or any other gene therapy or are being considered for treatment with any other gene therapy
- Have adequate organ function with no significant deterioration in organ function expected within 4 weeks after apheresis
- Do not have any of the following:
  - Burkitt lymphoma
  - Active hepatitis B, C, or any uncontrolled infection
  - Grade 2 to 4 graft-versus-host disease
  - Concomitant genetic syndrome with the exception of Down syndrome
  - Received allogeneic cellular therapy, such as donor lymphocyte infusion, within 6 weeks prior to tisagenlecleucel infusion
  - Patient has active central nervous system 3 acute lymphoblastic leukemia (ie, white blood cell count ≥5 cells/μL in cerebrospinal fluid with presence of lymphoblasts).
- The healthcare facility that dispenses and administers Kymriah is enrolled and complies with the Risk Evaluation and Mitigation Strategy known as Kymriah REMS, including:
  - Onsite, immediate access to tocilizumab
  - Availability of a minimum of two doses of tocilizumab for each patient for administration within 2 hours after Kymriah infusion, if needed for treatment of cytokine release syndrome
  - Assurance that healthcare providers who prescribe, dispense or administer Kymriah are trained in the management of cytokine release syndrome and neurologic toxicities.

a Relapsed disease describes the reappearance of leukemia cells in the bone marrow or peripheral blood after the attainment of a complete remission with chemotherapy and/or allogeneic cell transplant.

b Refractory (resistant) disease is defined as those patients who fail to obtain complete response with induction therapy, ie, failure to eradicate all detectable leukemia cells (<5% blasts) from the bone marrow and blood with subsequent restoration of normal hematopoiesis (>25% marrow cellularity and normal peripheral blood counts).

*Central nervous system (CNS) disease for B-cell acute lymphoblastic leukemia is defined by the following groups:
  - CNS 1: Absence of blasts on cerebrospinal fluid cytospin preparation, regardless of the white blood cell (WBC) count
  - CNS 2: WBC count of less than 5/mL and blasts on cytospin findings
  - CNS 3: WBC count of 5/mL or more and blasts on cytospin findings and/or clinical signs of CNS leukemia (eg, facial nerve palsy, brain/eye involvement, hypothalamic syndrome).

**Tisagenlecleucel (Kymriah): Non-Hodgkin lymphoma**

**CAR-T therapy with tisagenlecleucel intravenous** (except as indicated) infusion may be considered **MEDICALLY NECESSARY** for relapsed or refractory patients with aggressive types of non-Hodgkin lymphoma if they meet **all** of the following criteria:
- Are adults (age ≥18) at the time of infusion
- Histologically confirmed diagnosis of diffuse large B-cell lymphoma, not otherwise specified; or primary mediastinal large B-cell lymphoma or high-grade B-cell lymphoma or diffuse large B-cell lymphoma arising from follicular lymphoma.
- Received adequate prior therapy including all of the following:
  - Anti-CD20 monoclonal antibody for CD20-positive tumor
  - Anthracycline-containing chemotherapy regimen
  - For subjects with transformed follicular lymphoma, prior chemotherapy for follicular lymphoma and subsequently have chemorefractory disease after transformation to diffuse large B-cell lymphoma:
▪ If patient has a history of allogeneic stem cell transplant, has no signs of active graft versus host disease
▪ No active autoimmune disease requiring systemic immunosuppression
▪ Have adequate organ and bone marrow function as determined by the treating oncologist/hematologist
▪ Have not received prior CD19-directed CAR T-cell therapy treatment or any other gene therapy or are being considered for treatment with any other gene therapy

AND
• Do not have primary central nervous system lymphoma.
• The healthcare facility that dispenses and administers Yescarta is enrolled and complies with the Risk Evaluation and Mitigation Strategy including:
  o Onsite, immediate access to tocilizumab, AND
  o Availability of a minimum of two doses of tocilizumab for each patient for administration within 2 hours after Yescarta infusion, if needed for treatment of cytokine release syndrome, AND
  o Assurance that healthcare providers who prescribe, dispense or administer Yescarta are trained in the management of cytokine release syndrome and neurologic toxicities.

\(^a\)Tisagenlecleucel intravenous infusion is considered \textbf{INVESTIGATIONAL} for the treatment of relapsed or refractory primary mediastinal large B-cell lymphoma.

\(^b\)Relapsed or refractory disease, defined as progression after 2 or more lines of systemic therapy (which may or may not include therapy supported by autologous cell transplant).

\textbf{Axicabtagene ciloleucel (Yescarta): Non-Hodgkin lymphoma}

CAR-T therapy with axicabtagene ciloleucel infusion is considered \textbf{MEDICALLY NECESSARY} for relapsed or refractory\(^a\) patients with aggressive types of non-Hodgkin lymphoma if they meet all of the following criteria:

• Are adults (age \(\geq 18\)) at the time of infusion
• Histologically confirmed diagnosis of diffuse large B-cell lymphoma, not otherwise specified; or primary mediastinal large B-cell lymphoma or high-grade B-cell lymphoma or diffuse large B-cell lymphoma arising from follicular lymphoma.
• Received adequate prior therapy including all of the following:
  o Anti-CD20 monoclonal antibody for CD20-positive tumor
  o Anthracycline-containing chemotherapy regimen
  o For subjects with transformed follicular lymphoma, prior chemotherapy for follicular lymphoma and subsequently have chemorefractory disease after transformation to diffuse large B-cell lymphoma:
    ▪ Have adequate organ and bone marrow function as determined by the treating oncologist/hematologist
    ▪ Have not received prior CD19-directed CAR T-cell therapy treatment or any other gene therapy or are being considered for treatment with any other gene therapy.

AND
• Do not have primary central nervous system lymphoma.

\(^a\)Relapsed or refractory disease is defined as progression after 2 or more lines of systemic therapy (which may or may not include therapy supported by autologous cell transplant).

CAR-T therapy is considered \textbf{INVESTIGATIONAL} for all other applications.

\textbf{Prior Authorization Information}
\textbf{Inpatient}
• For services described in this policy, precertification/preauthorization \textbf{IS REQUIRED} for all products if the procedure is performed \textit{inpatient}.
Outpatient

- For services described in this policy, see below for products where prior authorization might be required if the procedure is performed outpatient.

<table>
<thead>
<tr>
<th>Product Type</th>
<th>Prior Authorization Requirement</th>
</tr>
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<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>Prior authorization is required.*</td>
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<tr>
<td>Commercial PPO and Indemnity</td>
<td>Prior authorization is required.*</td>
</tr>
<tr>
<td>Medicare HMO BlueSM</td>
<td>Prior authorization is required.*</td>
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<tr>
<td>Medicare PPO BlueSM</td>
<td>Prior authorization is required.*</td>
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</tbody>
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*Prior Authorization Request Form: Chimeric Antigen Receptor Therapy for Hematologic Malignancies

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- Click here for CAR T-Cell Therapy Services for B-cell Acute Lymphoblastic Leukemia (tisagenlecleucel) Prior Authorization Request Form #925

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable. The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

**HCPCS Codes**

<table>
<thead>
<tr>
<th>HCPCS codes</th>
<th>Code Description</th>
</tr>
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<tbody>
<tr>
<td>C9399</td>
<td>Unclassified drugs or biologicals</td>
</tr>
<tr>
<td>J3490</td>
<td>Unclassified drugs</td>
</tr>
<tr>
<td>J3590</td>
<td>Unclassified biologics</td>
</tr>
<tr>
<td>J9999</td>
<td>Not otherwise classified, antineoplastic drugs</td>
</tr>
<tr>
<td>Q2041</td>
<td>Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose</td>
</tr>
<tr>
<td>Q2042</td>
<td>Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose</td>
</tr>
</tbody>
</table>

**ICD-10 Procedure Codes**

<table>
<thead>
<tr>
<th>ICD-10-PCS procedure codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>XW033C3</td>
<td>Introduction of Engineered Autologous Chimeric Antigen Receptor T-cell Immunotherapy into Peripheral Vein, Percutaneous Approach, New Technology Group 3</td>
</tr>
<tr>
<td>XW043C3</td>
<td>Introduction of Engineered Autologous Chimeric Antigen Receptor T-cell Immunotherapy into Central Vein, Percutaneous Approach, New Technology Group 3</td>
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</tbody>
</table>
The following CPT codes are considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0537T</td>
<td>Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day</td>
</tr>
<tr>
<td>0538T</td>
<td>Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (eg, cryopreservation, storage)</td>
</tr>
<tr>
<td>0539T</td>
<td>Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration</td>
</tr>
<tr>
<td>0540T</td>
<td>Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous</td>
</tr>
</tbody>
</table>

**Description**

**Acute Lymphoblastic Leukemia (ALL)**

B-cell ALL is a malignancy (clonal) of the bone marrow in which the early lymphoid precursors of the white blood cells (called lymphoblasts) proliferate and replace the normal hematopoietic cells of the marrow. This results in overcrowding of the bone marrow, as well as the peripheral organs (particularly the liver, spleen, and lymph nodes) by the lymphoblasts. As a consequence, the leukemic blasts displace the normal hematopoietic bone marrow and cause cytopenias in all three cell lineages (anemia, thrombocytopenia, granulocytopenia). Leukostasis affecting brain and lung may also occur. Death occurs commonly due to severe pancytopenia and resulting infections. Refractory (resistant) disease is defined as those patients who fail to obtain a complete response with induction therapy, ie, failure to eradicate all detectable leukemia cells (<5% blasts) from the bone marrow and blood with subsequent restoration of normal hematopoiesis (>25% marrow cellularity and normal peripheral blood counts). Relapsed disease describes the reappearance of leukemia cells in the bone marrow or peripheral blood after the attainment of complete remission. Minimal residual disease (MRD) refers to the presence of disease in cases deemed to be in complete remission by conventional pathologic analysis. MRD positivity is defined as the presence of >0.01% or more ALL cells and has been shown to be a strongest prognostic factor to predict the risk of relapse and death when measured during and after induction therapy in both newly diagnosed and relapsed ALL. In a meta-analysis of 20 studies of 11249 pediatric ALL, Berry et al (2017) reported a hazard ratio for event-free survival in MRD-negative patients compared with MRD-positive patients of 0.23 (95% confidence interval, 0.18 to 0.28).1

Approximately 5000 cases of B-cell ALL are diagnosed every year in the United States,2 and approximately 620 pediatric and young adult patients with B-cell ALL will relapse each year in the United States.3 B-cell ALL is largely a disease of the young, with approximately 60% of cases occurring inpatients younger than 20 years old with a median age at diagnosis of 15 years.2

**Treatment**

While treatable in 85% cases, approximately 15% of children and young adults with ALL will relapse and 2% to 3% of ALL patients are primary refractory.4 Retreatment of refractory or relapsed ALL is generally unsuccessful and associated with a high mortality rate.5 The 2-year survival rate among patients with ALL who relapse after hematopoietic cell transplantation is 15%.6 The Food and Drug Administration (FDA) approved clofarabine (as a single agent or in combination) in 2004 and blinatumomab in 2014 for relapsed and refractory ALL. Reported median objective response rates in the pivotal trials of the 2 agents were 19.7% and 33%, the median durations of response were 2.5 months and 6 months, and median overall survival durations were 3 months and 7.5 months, respectively.7,8 Note that the percentages of patients treated with 3 or more prior treatments of clofarabine and blinatumomab trial were 62% and 7%, respectively. Nevertheless, treatment options for patients with relapsed or refractory ALL are limited, associated with poor outcomes and high toxicity and the disease remains incurable.
Diffuse Large B Cell Lymphoma (DLBCL)

DLBCL is the most common histologic subtype of non-Hodgkin lymphoma and accounts for approximately 25% of non-Hodgkin lymphoma cases. DLBCL exhibits large heterogeneity in morphologic, genetic, and clinical aspects and multiple clinicopathologic entities are defined by the 2016 World Health Organization classification, which are sufficiently distinct to be considered separate diagnostic categories. Teras et al (2016) has estimated that 27650 new cases of DLBCL were diagnosed in the United States in 2016.

Treatment

Treatment in the first-line setting (particularly rituximab plus cyclophosphamide, doxorubicin, vincristine, and prednisone) is associated with a 5-year survival rate ranging from 60% to 70%. However, based on a number of prognostic factors, 20% to 50% of DLBCL cases are refractory or relapse after first-line chemotherapy. The response to subsequent salvage chemotherapy and consolidation with autologous cell transplantation is suboptimal. A retrospective analysis of the SCHOLAR-1 study by Crump et al (2017), which pooled data from 2, phase 3 clinical trials and 2 observational cohorts, included 636 patients with refractory DLBCL. The objective response rate to the next line of therapy was 26%, with 7% achieving a complete response. Median overall survival was 6.3 months and 2-year survival 20%. Refractory DLBCL was defined as progressive disease or stable disease as best response at any point during chemotherapy (>4 cycles of first-line or 2 cycles of later-line therapy) or as relapse 12 or fewer months after autologous cell transplantation.

Adoptive Immunotherapy

Adoptive immunotherapy uses “activated” lymphocytes as a treatment modality. Both nonspecific and specific lymphocyte activation are used therapeutically. The nonspecific, polyclonal proliferation of lymphocytes by cytokines (immune system growth factors), also called auto lymphocyte therapy, increases the number of activated lymphocytes.

Initially, this treatment was performed by harvesting peripheral lymphokine-activated killer cells and activating them ex vivo with the T-cell growth factor interleukin-2 (IL-2) and other cytokines. More recent techniques have yielded select populations of cytotoxic T lymphocytes with specific reactivity to tumor antigens. Peripheral lymphocytes are propagated in vitro with antigen-presenting dendritic cells (DC) that have been pulsed with tumor antigens. Alternatively, innate tumor-infiltrating lymphocytes (TIL) from the tumor biopsy are propagated in vitro with IL-2 and anti-CD3 antibody, a T-cell activator. Expansion of TIL for clinical use is labor intensive and requires laboratory expertise. Only a few cancers are infiltrated by T cells in significant numbers; of these, TIL can be expanded in only approximately 50% of cases.

Adoptive Cell Transfer

The major research challenge in adoptive immunotherapy is to develop immune cells with antitumor reactivity in quantities sufficient for transfer to tumor-bearing patients.

Adoptive cellular therapy is “the administration of a patient’s own (autologous) or donor (allogeneic) antitumor lymphocytes following a lymphodepleting preparative regimen.” Protocols vary, but include these common steps:

1. lymphocyte harvesting (either from peripheral blood, tumor biopsy, or donor blood)
2. propagation of tumor-specific lymphocytes in vitro using various immune modulators
3. selection of lymphocytes with reactivity to tumor antigens and/or modification of lymphocytes to bear tumor-antigen targeted receptors
4. lymphodepletion of the host with immunosuppressive agents
5. adoptive transfer (ie, transfusion) of lymphocytes back into the tumor-bearing host.

In an attempt to regulate the host immune system further, recent protocols have used various cytokines (eg, IL-7 and IL-15 instead of IL-2) to propagate lymphocytes. Protocols also differ in the extent of host lymphodepletion induced prior to transfusing lymphocytes to the tumor-bearing host.
Allogeneic stem cell transplantation following nonmyeloablative conditioning of the recipient (ie, reduced-intensity conditioning) may also be referred to as “adoptive immunotherapy” in the literature. However, reduced-intensity conditioning cell transplantation relies on a donor-vs-malignancy effect of donor lymphocytes. In contrast, the adoptive immunotherapy techniques described in this evidence review enhance autoimmune effects primarily. The use of reduced-intensity conditioning in cell transplantation is discussed for specific cancers in individual policies related to stem cell transplantation.

Chimeric Antigen Receptor T Cell Therapy
Due to difficulties in expanding innate TILs, genetic modification techniques have been harnessed to decorate propagated T cells with engineered chimeric antigen receptors (CARs) that are composed of several functional components: a tumor antigen-targeting single chain variable fragment (scVF) (eg, anti-CD19), a hinge region, a T-cell activation domain (eg, CD3), and one or more costimulatory domains (eg, CD28, 4-1BB). Viral vector genetic modification approaches (eg, retroviral, lentiviral) have traditionally been used to transflect T cells with CAR genes.17

Tisagenlecleucel
Tisagenlecleucel is adoptive immunotherapy in which the T-cells of a patient are modified by genetic engineering using a lentiviral vector. The resulting genetic modified cells express a CD-19-directed chimeric antigen receptor protein that consists of an extracellular portion that has a murine anti-CD19 single-chain antibody fragment as well as an intracellular portion that contains T-cell signaling and co-stimulatory domains. Once injected, the genetically modified T-cells selectively target and bind to CD19 antigen expressed on the surface of B cells and tumors derived from B cells. Subsequently, the intracellular signaling domains play crucial roles in T-cell activation, persistence, and effector functions.18

Axicabtagene Ciloleucel
Similar to tisagenlecleucel, axicabtagene ciloleucel is adoptive immunotherapy in which the T-cells of a patient are modified genetically using a retroviral vector. The resulting genetically modified cells express a CD-19-directed chimeric antigen receptor protein that has a murine single-chain variable fragment with specificity for CD19. Once injected, the genetically modified T-cells selectively target and bind to CD19 antigen expressed on the surface of normal and malignant B cells.19

Summary
The spontaneous regression of certain cancers (eg, renal cell carcinoma, melanoma) supports the idea that a patient’s immune system can delay tumor progression and, on rare occasions, can eliminate tumors altogether. These observations have led to research into various immunotherapies designed to stimulate a patient’s own immune system. Chimeric antigen receptor T-cell therapy is a specific form of adoptive immunotherapy that involves harvesting cells from a patient or donor, a manufacturing process during which cells are genetically modified with engineered CAR protein to permit targeted activation and therapy, and infusion of cells into the patient.

Tisagenlecleucel
For individuals who are up to 25 years of age with relapsed or refractory B-cell acute lymphoblastic leukemia who receive tisagenlecleucel, the evidence includes a single-arm prospective trials. The relevant outcomes are OS, DSS, QOL, and treatment-related mortality and morbidity. The pivotal single-arm trials reported a 81% response rate (measured by complete response or complete remission with incomplete blood count) in heavily pretreated patients. All patients who achieved complete remission or complete remission with incomplete blood count were also minimal residual disease-negative, which is predictive of survival in acute lymphoblastic leukemia patients. After a median follow-up of 13.1 months, the median duration of response was not reached. The observed benefits seen with tisagenlecleucel were offset by a high frequency and severity of adverse events. Cytokine release syndrome was observed in more than half (77%) of the patients, and approximately 88% had an adverse event at grade 3 or higher. Long-term follow-up, real-world evidence, and post-marketing studies are required to assess the generalizability of tisagenlecleucel efficacy and safety outside of the clinical trial setting. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.
For individuals who are adults with a histologically confirmed diagnosis of aggressive non-Hodgkin lymphoma (eg, diffuse large B-cell lymphoma not otherwise specified, high-grade B-cell lymphoma, transformed follicular lymphoma) who receive tisagenlecleucel, the evidence includes a single-arm prospective trial. The relevant outcomes are OS, DSS, QOL, and treatment-related mortality and morbidity. The pivotal single-arm trial reported a 52% overall response rate (measured by complete or partial responses) in heavily pretreated patients. After a median follow-up of 14 months, the median duration of response was not reached. The observed benefits were offset by a high frequency and severity of adverse events. Any grade cytokine release syndrome was observed in 58% of the patients, and 63% had an adverse event at grade 3 or higher. Long-term follow-up, real-world evidence, and post-marketing studies are required to assess the generalizability of tisagenlecleucel efficacy and safety outside of the clinical trial setting. The manufacturer has agreed to a postmarketing requirement observational registry study to collect safety information for patients treated with the marketed product. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Axicabtagene Ciloleucel
For individuals who are adults with a histologically confirmed diagnosis of aggressive non-Hodgkin lymphoma (eg, diffuse large B-cell lymphoma not otherwise specified, high-grade B-cell lymphoma, primary mediastinal large B-cell lymphoma, transformed follicular lymphoma) who receive axicabtagene ciloleucel, the evidence includes a single-arm prospective trial. The relevant outcomes are OS, DSS, QOL, and treatment-related mortality and morbidity. The pivotal single-arm trial reported a 83% overall response rate (measured by complete or partial remission) in heavily pretreated patients. After a median follow-up of 27.1 months, the median duration of response was 11.1 months. The observed benefits were offset by a high frequency and severity of adverse events. Cytokine release syndrome was observed in more than half of the patients, and 98% had an adverse event at grade 3 or higher. Long-term follow-up and real-world evidence are required to assess the generalizability of axicabtagene ciloleucel efficacy and safety outside of the clinical trial setting. The manufacturer has agreed to a postmarketing requirement observational registry study to collect safety information for patients treated with the marketed product. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/2019</td>
<td>New policy created from policy #455 Adoptive Immunotherapy. FDA-approved tisagenlecleucel (Kymriah) and axicabtagene ciloleucel (Yescarta) therapies were moved from policy #455 to create a new standalone policy #066 Chimeric Antigen Receptor Therapy for Hematologic Malignancies. Policy statements unchanged.</td>
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<tr>
<td>1/2019</td>
<td>Clarified coding information.</td>
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<tr>
<td>6/2018</td>
<td>BCBSA National medical policy review. Policy statement clarified, changing “2 or 3” to “3”, to read: &quot;Patient has active central nervous system 3 acute lymphoblastic leukemia (ie, white blood cell count ≥5 cells/μL in cerebrospinal fluid with presence of lymphoblasts).” Prior Authorization Information reformatted.</td>
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<td>4/2018</td>
<td>Clarified coding information.</td>
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<tr>
<td>1/2018</td>
<td>Clarified coding information. Preauthorization request form for Yescarta and Kymriah added.</td>
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</tbody>
</table>

Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:
- Medical Policy Terms of Use
- Managed Care Guidelines
- Indemnity/PPO Guidelines
- Clinical Exception Process
- Medical Technology Assessment Guidelines

References


