Reference number(s)
2228-A

SPECIALTY GUIDELINE MANAGEMENT

BLINCYTO (blinatumomab)

POLICY

I. 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.

A. FDA-Approved Indications
Philadelphia chromosome-negative relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL)

B. Compendial Uses
Relapsed/refractory Philadelphia chromosome-positive B-cell precursor ALL

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 9 months may be granted for treatment of precursor B-cell acute lymphoblastic leukemia (ALL).

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Blincyto [package insert]. Thousand Oaks, CA: Amgen Inc.; July 2017.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed October 14, 2017.
3. The NCCN Clinical Practice Guidelines in Oncology® Acute Lymphoblastic Leukemia (Version 4.2017) © 2017 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed October 14, 2017.