Reference number(s)
2831-A

SPECIALTY GUIDELINE MANAGEMENT

ELZONRIS (tagraxofusp-erzs)

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.

FDA-Approved Indication
Elzonris is a CD123-directed cytotoxin for the treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN) in adults and in pediatric patients 2 years and older.

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

II. CRITERIA FOR INITIAL APPROVAL

Blastic plasmacytoid dendritic cell neoplasm (BPDCN)
Authorization of 12 months may be granted for treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN) when the patient's disease is positive for CD123 expression.

III. CONTINUATION OF THERAPY

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

IV. REFERENCES

1. Elzonris [package insert]. New York, NY: Stemline Therapeutics, Inc.; December 2018.