

Reference number(s)
2652-A

## SPECIALTY GUIDELINE MANAGEMENT

### POTELIGEO (mogamulizumab-kpkc)

#### 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

Poteligeo is indicated for the treatment of adult patients with relapsed or refractory mycosis fungoides (MF) or Sézary syndrome (SS) after at least one prior systemic therapy.

###### B. Compendial Uses

1. Mycosis fungoides (MF) or Sézary syndrome (SS) as primary treatment
2. Adult T-cell leukemia/lymphoma

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

##### II. CRITERIA FOR INITIAL APPROVAL

###### A. **Mycosis fungoides (MF) or Sézary syndrome (SS)**

Authorization of 12 months may be granted for treatment of mycosis fungoides (MF) or Sézary syndrome (SS).

###### B. **Adult T-cell leukemia/lymphoma**

Authorization of 12 months may be granted for treatment of adult T-cell leukemia/lymphoma.

##### III. CONTINUATION OF THERAPY

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