Medical Necessity Guidelines:
Carvykti™ (cilta-cabtagene autoleucel)

Effective: January 1, 2023

Prior Authorization Required
If REQUIRED, submit supporting clinical documentation pertinent to service request.

Appplies to:

Commercial Products
- Harvard Pilgrim Health Care Commercial products; Fax 617-673-0988
- Tufts Health Plan Commercial products; Fax 617-673-0988
  CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products
- Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 617-673-0988
- Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax 617-673-0988
- Tufts Health RItogether – A Rhode Island Medicaid Plan; Fax 617-673-0988
- Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax 617-673-0956
  *The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

Senior Products
- Harvard Pilgrim Health Care Stride Medicare Advantage; Fax 617-673-0956
- 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 CART cells may remain in the body long after the infusion, it is possible the treatment can bring about long-term remission. CART 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:
- Carvykti™ (cilta-cabtagene autoleucel) is a B-cell maturation antigen (BCMA)-directed genetically modified autologous T cell immunotherapy indicated for the treatment of adult patients with relapsed or refractory multiple myeloma after four or more prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody.

REMS Program: Carvykti™ is managed under a Risk Evaluation Mitigation Strategy (REMS) program per the Food and Drug Administration (FDA) to manage or reduce the incidence of known or potential serious risks associated with Carvykti™ therapy. The purpose of the CARVYKTI REMS is to mitigate the risks of cytokine release syndrome (CRS) and neurological toxicities by:
• Ensuring that Hospitals and their Associated Clinics that dispense CARVYKTI are specially certified and have on-site, immediate access to tocilizumab.
• Ensuring those who prescribe, dispense, or administer CARVYKTI are aware of how to manage the risks of CRS and neurological toxicities.

Hospitals and their Associated Clinics must be certified in the CARVYKTI REMS in order to treat patients with CARVYKTI. For additional information, go to https://www.carvyktirems.com/ or call 1-844-672-0067.

NATIONAL COVERAGE DETERMINATION (NCD)

Nationally Covered Indication(s):
• Effective for services performed on or after August 7, 2019, the Centers for Medicare & Medicaid Services (CMS) covers autologous treatment for cancer with T-cells expressing at least one CHIMERIC antigen receptor (CAR) when administered at healthcare facilities enrolled in the FDA risk evaluation and mitigation strategies (REMS) and used for a medically accepted indication as defined at Social Security Act section 1861(t)(2)-i.e., is used for either an FDA-approved indication (according to the FDA-approved label for that product), or for other uses when the product has been FDA-approved and the use is supported in one or more CMS-approved compendia.

Nationally Non-Covered:
• Effective for services performed on or after August 7, 2019, the use of non-FDA-approved autologous T-cells expressing at least one CAR is non-covered. Autologous treatment for cancer with T-cells expressing at least one CAR is non-covered when the requirements in Section A are not met.

Clinical Guideline Coverage Criteria
The Plan may cover Carvykti™ (ciltacabtagene autoleucel) for Members when all the following clinical criteria are met:

1. The Member has a documented diagnosis of relapsed* or refractory* multiple myeloma
AND
2. There is documentation to support that the Member has already been treated with four or more prior lines of therapy including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody
AND
3. The Member is receiving treatment at a facility that is certified and enrolled in the Carvykti REMS Program
AND
4. The Member 18 years of age or older

*Relapsed/Refractory defined as disease progression after last the treatment regimen or refractory/suboptimal response to the most recent therapy

Note: Documentation submitted must list previous lines of treatment/systemic therapies and date of each therapy.
Note: Refer to Center for Medicare and Medicaid National Coverage Determination (NCD) for Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) at https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=374&bc=CAAAAAAAAAAAA

Limitations
• Authorization for Carvykti (ciltacabtagene autoleucel) is limited to a one-time infusion
• 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
• All other indications other than those listed above are considered experimental/investigational and not medically necessary

Codes
The following code(s) require prior authorization:

Table 1: HCPCS Codes

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>Q2056</td>
<td>Ciltacabtagene autoleucel, up to 100 million autologous B-cell maturation antigen (BCMA) directed CAR-positive T cells, including leukapheresis and dose preparation procedures, per therapeutic dose</td>
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Table 2: CPT Codes

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
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<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>
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<tr>
<td>0538T</td>
<td>Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (e.g., cryopreservation, storage)</td>
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<tr>
<td>0539T</td>
<td>Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration</td>
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<tr>
<td>0540T</td>
<td>Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous</td>
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References:

Approval And Revision History
September 13, 2022: Reviewed by Pharmacy and Therapeutics Committee (P&T)
September 21, 2022: Reviewed by the Medical Policy Approval Committee (MPAC)

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.