
Chemotherapy: Drugs A-D Policy

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This section contains policy related to billing for injection services, listed in alphabetical order by generic drug name or drug type. For general billing policy information regarding injections services, refer to the *Chemotherapy: An Overview* section in this manual. Additional policy information for chemotherapy drug services can be found in the *Chemotherapy: Drugs E-O Policy* and *Chemotherapy: Drugs P-Z Policy* sections in this manual.

Ado-Trastuzumab Emtansine

Ado-trastuzumab emtansine is a Human Epidermal Growth Factor Receptor 2 (HER2)-targeted antibody-drug conjugate which contains the humanized anti-HER2 IgG1, trastuzumab, covalently linked to the microtubule inhibitory drug DM1 (a maytansine derivative) via the stable thioether linker MCC (4-[N- maleimidomethyl] cyclohexane-1-carboxylate). Emtansine refers to the MCC- DM1 complex. Upon binding to sub-domain IV of the HER2 receptor, ado- trastuzumab emtansine undergoes receptor-mediated internalization and subsequent lysosomal degradation, resulting in intracellular release of DM1-containing cytotoxic catabolites. Binding of DM1 to tubulin disrupts microtubule networks in the cell, which results in cell cycle arrest and apoptotic cell death.

Indications

For the treatment of patients with HER2 positive metastatic breast cancer who previously received trastuzumab and a taxane, separately or in combination. They should have either:

- Received prior therapy for metastatic disease, or
- Developed disease recurrence during or within six months of completing adjuvant therapy

Authorization

An approved *Treatment Authorization Request* (TAR) is required for reimbursement. Documentation must be submitted with the TAR to establish medical necessity.

Dosage

The recommended dose of ado-trastuzumab emtansine is 3.6 mg/kg given as an intravenous infusion every three weeks (21-day cycle) until disease progression or unacceptable toxicity. Ado-trastuzumab emtansine should not be administered at doses greater than 3.6 mg/kg nor should it be substituted for or used with trastuzumab.

Billing

HPCS code J9354 (injection, ado-trastuzumab emtansine, 1 mg)

Aldesleukin

Aldesleukin is a lymphokine that stimulates growth of T-lymphocytes. Aldesleukin is used to treat metastatic renal cell carcinoma and metastatic malignant melanoma. It is a “biologic response modifier” that promotes anti-tumor activity mediated through the immune system.

Required Codes

Aldesleukin is reimbursable when billed in conjunction with ICD-10-CM diagnosis codes C43.0 thru C43.9 (malignant melanoma of skin), C64.1 thru C65.9 (malignant neoplasm of kidney and renal pelvis).

Dosage

Adult patients diagnosed with metastatic renal cell carcinoma or metastatic malignant melanoma may be treated with a dosage schedule consisting of two five-day treatment cycles separated by a rest period of nine days. Patients receive a dose of 600,000 IU/kg of aldesleukin administered every eight hours through a 15-minute intravenous infusion, for a total of 14 doses. Following the rest period, the schedule is repeated for another 14 doses, to a maximum of 28 doses per course.

Billing

HCPCS code J9015 (injection, aldesleukin, per single use vial)

Aldesleukin may be billed in conjunction with CPT® code 96413 (chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug).

Amivantamab-vmjw (Rybrevant)

Amivantamab-vmjw is a bispecific antibody that binds to the extracellular domains of epidermal growth factor receptor (EGFR) and mesenchymal-epithelial transition (MET). In in vitro and in vivo studies amivantamab-vmjw was able to disrupt EGFR and MET signaling functions through blocking ligand binding and, in exon 20 insertion mutation models, degradation of EGFR and MET. The presence of EGFR and MET on the surface of tumor cells also allows for targeting of these cells for destruction by immune effector cells, such as natural killer cells and macrophages, through antibody-dependent cellular cytotoxicity (ADCC) and trogocytosis mechanisms, respectively.

Indications

All FDA-approved indications

Age Limit

Must be 18 years of age or older

Dosage

FDA-approved dosages

TAR Requirement

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Billing

«HCPCS code J9061, (injection, amivantamab-vmjw, 2 mg)»

Prescribing Restrictions

Frequency of billing equals «1,400 mg/700» units weekly for 4 weeks, then every 2 weeks thereafter. Note that the initial dose is administered as a split infusion in week 1 on days 1 and 2.

«Maximum billing unit(s) = 1,400 mg/700 units»

Aprepitant

Aprepitant injection is a substance P/neurokinin-1 (NK-1) receptor antagonist anti-emetic drug for intravenous (I.V.) administration.

Indications

Aprepitant is used in combination with dexamethasone and a 5-HT₃ receptor antagonist to prevent nausea and vomiting symptoms associated with initial and repeat courses of highly-emetic cancer chemotherapy (HEC) or moderately-emetic cancer chemotherapy (MEC).

Age

18 years and older

Dosage

Single Dose Regimen for HEC:

- 130 mg I.V. given as a single dose approximately 30 minutes before initiation of a chemotherapy cycle.

Multiple Dose Regimen for MEC

- 100 mg I.V. given approximately 30 minutes before initiation of a chemotherapy cycle on Day 1, followed by an 80 mg aprepitant oral capsule given once daily on Days 2 and 3.

Authorization

No *Treatment Authorization Request* (TAR) is generally required for reimbursement, unless the claim exceeds the recommended maximum dose or frequency.

Required Codes

The following ICD-10-CM diagnosis code is required for reimbursement:

- Z51.11 (Encounter for anti-neoplastic chemotherapy)

Billing

HCPCS code J0185 (injection, aprepitant, 1 mg)

One (1) unit of J0185 = 1 mg of aprepitant emulsion

Arsenic Trioxide

The mechanism of action of arsenic trioxide is not completely understood. Arsenic trioxide causes morphological changes and DNA fragmentation characteristic of apoptosis in NB4 human promyelocytic leukemia cells in vitro.

Indications

For the induction of remission and consolidation in patients 4 years of age and older with acute promyelocytic leukemia (APL) who are refractory to, or have relapsed from, retinoid and anthracycline chemotherapy, and whose APL is characterized by the presence of the t(15;17) translocation or PML/RAR alpha gene expression.

Dosage

Recommended induction treatment schedule:

Intravenously at a dose of 0.15 mg/kg daily until bone marrow remission. Total induction dose should not exceed 60 doses.

Recommended consolidation treatment schedule:

Intravenously at a dose of 0.15 mg/kg daily for 25 doses over a period of five weeks.

Required Codes

Arsenic trioxide is reimbursable when billed with one of the following ICD-10-CM diagnosis codes:

- C92.40
- C92.41
- C92.42

Billing

HCPCS code J9017 (injection, arsenic trioxide, 1 mg)

Asparaginase *Erwinia Chrysanthemi*

Asparaginase *Erwinia chrysanthemi* contains an asparaginase specific enzyme derived from *Erwinia chrysanthemi*. Asparaginase *Erwinia chrysanthemi* catalyzes the deamidation of asparagine to aspartic acid and ammonia, resulting in a reduction in circulating levels of asparagine. The mechanism of action of asparaginase *Erwinia chrysanthemi* is thought to be based on the inability of leukemic cells to synthesize asparagine due to lack of asparagine synthetase activity, resulting in cytotoxicity specific for leukemic cells that depend on an exogenous source of the amino acid asparagine for their protein metabolism and survival.

Indications

For the treatment of patients with acute lymphoblastic leukemia who have developed hypersensitivity to *E. coli*-derived asparaginase.

Dosage

To substitute for a dose of pegaspargase:

The recommended dose is 25,000 International Units/m² administered intramuscularly three times a week (Monday/Wednesday/Friday) for six doses for each planned dose of pegaspargase.

To substitute for a dose of native *E. coli* asparaginase:

The recommended dose is 25,000 International Units/m² administered intramuscularly for each scheduled dose of native *E. coli* asparaginase within a treatment.

Maximum dose of 50,000 units unless there is documentation that patient's body surface area (BSA) is greater than 2.6 m².

Required Codes

Asparaginase *Erwinia chrysanthemi* is reimbursable when billed with one of the following ICD-10-CM diagnosis codes:

C91.00 or C91.02

Billing

HCPCS code J9019 (injection asparaginase [erwinaze], 1,000 IU)

«Asparaginase Erwinia Chrysanthemi (recombinant)

Rywn (Rylaze™)

Asparaginase erwinia chrysanthemi (recombinant)-rywn is an enzyme that catalyzes the conversion of the amino acid L-asparagine into aspartic acid and ammonia. The pharmacological effect of Rylaze is based on the killing of leukemic cells due to depletion of plasma asparagine. Leukemic cells with low expression of asparagine synthetase have a reduced ability to synthesize asparagine, and therefore depend on an exogenous source of asparagine for survival.

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

TAR Requirement

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Billing

HCPCS code J9021, (injection, asparaginase, recombinant, [Rylaze], 0.1 mg)

Suggested ICD-10-CM Diagnosis Codes

C91.00, C91.01, C91.02»»

Atezolizumab (Tecentrig®)

Atezolizumab is a humanized monoclonal antibody immune checkpoint inhibitor that binds to programmed death ligand 1 (PD-L1) to selectively prevent the interaction between the programmed cell death-1 (PD-1) and B7.1 (also known as CD80) receptors, while still allowing interaction between PD-L2 and PD-1. PD-L1 is an immune checkpoint protein expressed on tumor cells and tumor infiltrating cells and down regulates anti-tumor t-cell function by binding to PD-1 and B7.1; blocking PD-1 and B7.1 interactions restores antitumor t-cell function. Immune checkpoint inhibition combined with the mitogen-activated protein kinase (MAPK) pathway increase antigen presentation and T-cell infiltration/activation to suppress tumor growth and improve tumor immunogenicity (when compared to targeted therapy alone).

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

TAR Requirement

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Age Limits

Must be 18 years of age or older

Billing

HCPCS code J9022 (injection, atezolizumab, 10 mg)

Suggested ICD-10 Diagnosis Codes

Breast Cancer

C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119
C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229
C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419
C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529
C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819
C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929

Hepatocellular Carcinoma

C22.0, C22.1, C22.2, C22.3, C22.4, C22.7, C22.8, C22.9

Lung Cancer

C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2

Melanoma

C43.0, C43.10, C43.111, C43.112, C43.121, C43.122, C43.20, C43.21, C43.22, C43.30
C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71
C43.72, C43.8, C43.9

Urothelial Carcinoma

C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0, C67.1, C67.2, C67.3, C67.4, C67.5,
C67.6, C67.7, C67.8, C67.9, C68.0

Prescribing Restrictions

Maximum billing unit (s) equals 1680mg/168 units.

Avelumab (Bravencio®)

Avelumab is a programmed death ligand-1 (PD-L1) blocking antibody. PD-L1 may be expressed on tumor cells and tumor-infiltrating immune cells and can contribute to the inhibition of the anti-tumor immune response in the tumor microenvironment. Binding of PD-L1 to the PD-1 and B7.1 receptors found on T cells and antigen presenting cells suppresses cytotoxic T-cell activity, T-cell proliferation and cytokine production. Avelumab binds PD-L1 and blocks the interaction between PD-L1 and its receptors PD-1 and B7.1. This interaction releases the inhibitory effects of PD-L1 on the immune response resulting in the restoration of immune responses, including anti-tumor immune responses.

Indications

FDA approved indications

Dosage

FDA approved dosages

Authorization

No *Treatment Authorization Request* (TAR) is required for reimbursement

Age Limits

Must be 12 years of age or older

Billing

HCPCS code J9023 (injection, avelumab, 10 mg)

One (1) unit of J9023 equals 10 mg of avelumab

Prescribing Restrictions

Frequency of billing equals 800 mg/80 units every 2 weeks

Maximum billing unit(s) equals 800 mg/80 units

«Axicabtagene ciloleucel (Yescarta®)

YESCARTA, a CD19 (Cluster of Differentiation 19)-directed genetically modified autologous T cell immunotherapy binds to CD19-expressing cancer cells and normal B cells. Studies demonstrated that following anti-CD19 CAR T cell engagement with CD19-expressing target cells, the CD28 and CD3-zeta co stimulatory domains activate downstream signaling cascades that lead to T cell activation, proliferation, acquisition of effector functions and secretion of inflammatory cytokines and chemokines. This sequence of events leads to killing CD19-expressing cells.

Indications

All FDA-approved indications.

Dosage

FDA-approved dosages.»»

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

TAR Criteria

Yescarta is considered medically necessary when all of the following criteria are met:

«Universal criteria:

- Must be used for FDA-approved indications and dosages
- Patient must be 18 years of age or older
- Must be prescribed by or in consultation with an oncologist or hematologist
- Patient has an ECOG (Eastern Cooperative Oncology Group) performance status of 0 or 1
- Patient does not have the following:
 - Primary central nervous system lymphoma
 - Active or serious infection or inflammatory disorders
- Patient must have adequate bone marrow, cardiac, pulmonary, renal hepatic and organ functions
- Healthcare facility is enrolled in the Yescarta and Tecartus REMS (Risk Evaluation and Mitigation Strategy) Program
- Outpatient administration is restricted to Hospital Outpatient Services only
- Patient has not previously received treatment with a CAR T-cell immunotherapy»

A. Relapsed or refractory large B-cell lymphoma:

- Patient must meet the above universal criteria.
- Patient has one of the following histologically proven large B-cell lymphoma as defined by the World Health Organization (WHO) 2016 (Swerdlow et al, 2016).
 - Diffuse large B-cell lymphoma (DLBCL) not otherwise specified [activated B cell (ABC) or germinal center B cell (GCB)]
 - High grade B-cell lymphoma (HGBCL) with or without MYC and BCL2 and/or BCL6 rearrangement
 - DLBCL arising from follicular lymphoma (FL) or Transformation Follicular Lymphoma (TFL)
 - T-cell/histiocyte rich large B-cell lymphoma
 - DLBCL associated with chronic inflammation
 - Primary cutaneous DLBCL, leg type
 - Epstein-Barr virus (EBV) + DLBCL

Treatment is based on 1 or 2 below:

1. Patient had relapsed or refractory disease after first-line chemoimmunotherapy (includes rituximab and anthracycline)
 - Refractory disease defined as no complete remission to first-line therapy.
 - Patient had disease progression after first-line therapy or;
 - Patient had stable disease after at least four cycles of first-line therapy (for example, four cycles of R-CHOP ([rituximab, cyclophosphamide, doxorubicin, vincristine and prednisone]), or
 - Patient had partial response after at least six cycles and biopsy-proven residual disease or disease progression with less than or equal to 12 months of therapy
 - Relapsed disease defined as complete remission to first-line therapy followed by biopsy-proven relapse with less than or equal to 12 months of first-line therapy.
 - Patient must have received adequate first-line therapy including at a minimum:
 - Anti-CD20 monoclonal antibody (for example, rituximab) unless tumor is CD20 negative, and
 - An anthracycline containing chemotherapy regimen (for example, doxorubicin)
 - Patient has not received more than one line of therapy for DLBCL.
 - Patient does not have primary mediastinal B-cell lymphoma.
 - Patient has not received autologous or allogeneic stem cell transplant.

2. Patient has relapsed or refractory large B-cell lymphoma including DLBCL, PMBCL, TFL and HGBCL after two or more lines of systemic therapy.
 - Therapy includes at a minimum anti-CD20 monoclonal antibody unless the tumor is CD20-negative and an anthracycline containing chemotherapy regimen (for example, doxorubicin).
 - Patient may have primary mediastinal large B-cell lymphoma (PMBCL).
 - Patient had chemotherapy-refractory disease defined as no response to the most recent therapy or relapse within one year after autologous hematopoietic stem cell transplantation (HSCT).
 - Patient did not have prior allogeneic hematopoietic stem cell transplant (HSCT).

B. Relapsed or refractory follicular lymphoma:

- Patient meets the above universal criteria.
- Patient has a histologically confirmed diagnosis of follicular lymphoma.
- Patient has relapsed or refractory disease, defined as progression after two or more lines of systemic therapy (including the combination of an anti-CD20 monoclonal antibody (for example rituximab, obinutuzumab, etc) and an alkylating agent [e.g., R-bendamustine, R-CHOP]).
- Patient does not have transformed lymphoma or other aggressive lymphomas
- Patient did not have prior allogeneic hematopoietic stem cell transplant (HSCT)

Initial approval is for three months (one treatment only).

Reauthorization

Repeat treatment is not approvable.

YESCARTA and TECARTUS REMS:

The goals of the Yescarta and Tecartus REMS are to mitigate the risks of cytokine release syndrome (CRS) and neurological toxicities by:

1. Ensuring that hospitals and their associated clinics that dispense Yescarta and/or Tecartus are specially certified and have on-site, immediate access to tocilizumab.
2. Ensuring those who prescribe, dispense, or administer Yescarta and/or Tecartus are aware of how to manage the risks of CRS and neurological toxicities.

Age Limits

Must be 18 years of age or older.

Billing

HCPCS code Q2041 (Axicabtagene ciloleucel, up to 200 million autologous anti-CD19 CAR T cells, including leukapheresis and dose preparation procedures, per therapeutic dose).

One unit of Q2041 equals a single infusion of up to 200 million autologous anti-CD19 CAR-positive viable T cells.

Administration code: CPT code 96413 (chemo administration, intravenous infusion; up to one hour, single or initial substance or drug).

Important Instructions for Billing

Due to system limitations, providers are to take the following steps when submitting claims for Yescarta:

1. Submit and receive back an approved TAR/Service Authorization Request (SAR)
2. Bill using Q2041 (Axicabtagene ciloleucel, up to 200 million autologous anti-CD19 car-positive viable T cells, including leukapheresis and dose preparation procedures per therapeutic dose).
3. Completion of claim forms:
 - Claims are restricted to hospital outpatient services. Note that claims from pharmacies and clinics will be denied
 - Outpatient claims may be billed by paper claim using *UB-04* or electronically using 837I
 - «Providers must submit one service line on the TAR/SAR request and enter “5” in the Units box»
 - On the 837I or *UB-04* claim form, providers must submit one claim line to represent one service
 - ❖ Claims submitted with more than one claim line will be denied
 - Providers must submit an invoice for reimbursement
 - «This process will ensure that the total reimbursement paid for the quantity of five is no more than the paid price on the provider submitted invoice»
 - Yescarta must be billed on its own with no other drug or biological

4. For instructions regarding physician claim form completion, refer to the [Forms](#) page on the [Medi-Cal Providers website](#) for completion of 837I and [UB-04 claim forms](#).
5. Providers may bill separately for the administration (infusion) of the CAR-T cell using CPT code 96413

Suggested ICD-10-CM Diagnosis Codes

C82.00 thru C82.09, C82.10 thru C82.19, C82.20 thru C82.29, C82.30 thru C82.39, C82.40 thru C82.49, C82.50 thru C82.59, C82.60 thru C82.69, C82.80 thru C82.89, C82.90 thru C82.99, C83.30 thru C83.39, C85.10 thru C85.19, C85.20 thru C85.29, C85.80 thru C85.89.

Prescribing Restrictions

Frequency of billing is once in a lifetime.

Azacitidine

Azacitidine is a pyrimidine nucleoside analog of cytidine and is believed to exert its antineoplastic effects by causing hypomethylation of DNA and direct cytotoxicity on abnormal hematopoietic cells in the bone marrow.

Indications

Azacitidine is indicated for treatment of patients with:

- Refractory anemia
- Refractory anemia with ringed sideroblasts (if accompanied by neutropenia or thrombocytopenia or requiring transfusions)
- Refractory anemia with excess blasts or excess blasts in transformation
- Chronic myelomonocytic leukemia
- Acute myeloid leukemia

Dosage

The recommended starting dosage of azacitidine is 75 mg/m², given subcutaneously or intravenously once a day for seven days. This is usually repeated every four weeks for at least four cycles, and then continued as long as the patient continues to improve. The dosage may be increased to a maximum of 100 mg/m² if there is no initial response to treatment.

Billing

HCPCS code J9025 (injection, azacitidine, 1 mg)

Azacitidine is reimbursable for either intravenous or subcutaneous administration. Azacitidine may be billed either as an I.V. push or I.V. infusion over 40 minutes.

Note: Refer to the *Chemotherapy: An Overview* section of this manual for both subcutaneous injection and I.V. infusion administration billing codes.

BCG Live Intravesical

BCG Live is an attenuated, live culture preparation of the Bacillus of Calmette and Guerin (BCG) strain of *Mycobacterium bovis* for intravesical instillation.

Indications

BCG Live intravesical is used for the following indications:

- Carcinoma *in situ* (CIS) of the urinary bladder
- Primary or recurrent state Ta and/or T1 papillary tumors following transurethral resection (TUR)

BCG Live is not indicated for treatment of papillary tumors of stages higher than T1.

Age

18 years and older

Dosage

The recommended dose for the intravesical treatment of CIS and for the prophylaxis of recurrent papillary tumors consists of one vial of BCG Live suspended in 50 mL of preservative-free saline.

Authorization

No *Treatment Authorization Request* (TAR) is generally required for reimbursement.

Required Codes

Do not report in conjunction with CPT code 90586.

Billing

HCPCS code J9030 (injection, BCG live intravesical instillation, 1 mg)

One (1) unit of J9030 equals 1 mg of BCG live colony-forming units (CFU)

Belantamab mafodotin-blmf (BLENREP®)

Belantamab mafodotin-blmf is an antibody-drug conjugate (ADC). The antibody component is an afucosylated IgG1 directed against BCMA, a protein expressed on normal B lymphocytes and multiple myeloma cells. The small molecule component is MMAF, a microtubule inhibitor. Upon binding to BCMA, belantamab mafodotin-blmf is internalized followed by release of MMAF via proteolytic cleavage. The released MMAF intracellularly disrupts the microtubule network, leading to cell cycle arrest and apoptosis. Belantamab mafodotin-blmf had antitumor activity in multiple myeloma cells and mediated killing of tumor cells through MMAF-induced apoptosis, as well as by tumor cell lysis through antibody-dependent cellular cytotoxicity (ADCC) and antibody-dependent cellular phagocytosis (ADCP).

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

Authorization

No *Treatment Authorization Request* (TAR) is required for reimbursement.

REMS Program

Belantamab mafodotin-blmf is available only through a restricted program under a Risk Evaluation and Management Strategy (REMS) called the Blenrep REMS because of the risks of ocular toxicity.

Notable requirements of the Blenrep REMS include the following:

- Prescribers must be certified with the program by enrolling and completing training in the Blenrep REMS
- Prescribers must counsel patients receiving belantamab mafodotin-blmf about the risk of ocular toxicity and the need for ophthalmic examinations prior to each dose
- Patients must be enrolled in the Blenrep REMS and comply with monitoring
- Healthcare facilities must be certified with the program and verify that patients are authorized to receive belantamab mafodotin-blmf
- Wholesalers and distributors must only distribute belantamab mafodotin-blmf to certified healthcare facilities

Further information is available at <http://www.blenrepregs.com> and 1-855-209-9188.

Age Limits

Must be 18 years of age or older

Billing

HCPCS code J9037 (injection, belantamab mafodotin-blmf, 0.5 mg)

Suggested ICD-10-CM Diagnosis Codes

C90.00, C90.02

Prescribing Restrictions

Frequency of billing = 2.5 mg/kg once every 21 days

Belinostat

Belinostat is a histone deacetylase inhibitor and catalyzes the removal of acetyl groups from the lysine residues of histones and some non-histone proteins. In vitro, belinostat caused the accumulation of acetylated histones and other proteins, inducing cell cycle arrest and/or apoptosis of some transformed cells with preferential cytotoxicity towards tumor cells compared to normal cells.

Indications

For the treatment of patients 18 years of age and older with relapsed or refractory peripheral T-cell lymphoma.

Authorization

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Dosage

The recommended dose is 1,000 mg/m² once daily on days 1 through 5 of a 21-day cycle.

Billing

HCPCS code J9032 (injection, belinostat, 10 mg)

Bendamustine HCl

Bendamustine hydrochloride (HCl) is an alkylating agent for intravenous (I.V.) administration.

Indications

Bendamustine HCl is used to treat the following conditions:

- Chronic lymphocytic leukemia (CLL)
- Indolent B-cell non-Hodgkin's lymphoma (NHL)
 - Disease refractory to rituximab or relapsed within six months of a rituximab-containing treatment regimen.

Age

18 years and older

Dosage

The recommended dosage varies based on the treatment condition and subsequent level of organ system toxicity.

Authorization

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

The TAR must include clinical documentation that demonstrates all of the following:

- The service is medically necessary.
- Alternative treatments have been tried or considered, have failed, or are contraindicated.
- The physician's legible, complete, and signed treatment plan/order for bendamustine HCl.

Billing

«HCPCS code J9033, one unit (injection, bendamustine HCl [treanda], 1 mg)

HCPCS code J9034, one unit (injection, bendamustine HCl [bendeka], 1 mg)»

«Bendamustine Hydrochloride

Bendamustine is an alkylating agent (nitrogen mustard derivative) with a benzimidazole ring (purine analog) which demonstrates only partial cross-resistance (in vitro) with other alkylating agents. It leads to cell death via single and double strand DNA cross-linking. Bendamustine is active against quiescent and dividing cells. The primary cytotoxic activity is due to bendamustine (as compared to metabolites).

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

TAR Criteria

Must submit clinical documentation to substantiate the following:

Universal Criteria:

- Must be used for FDA approved indications and dosages
- Prescribed or in consultation with an oncologist
- Patient is at least 18 years of age
- Patient has chronic lymphocytic leukemia (CLL) or indolent B-cell non-Hodgkin lymphoma (NHL):

A. Chronic lymphocytic leukemia (CLL):

- Patient has not received bendamustine therapy in the past, unless otherwise specified
- Patient does not have autoimmune hemolytic anemia or autoimmune thrombocytopenia, Richter's syndrome, or transformation to prolymphocytic leukemia

B. Indolent B-cell non-Hodgkin lymphoma (NHL):

- Patient has not received bendamustine therapy in the past, unless otherwise specified
- Patient with relapse within 6 months of either the first dose (monotherapy) or last dose (maintenance regimen or combination therapy) of rituximab

Authorization is for 6 months»

«Age Limits

Must be 18 years of age or older

Billing

HCPCS codes:

- J9056 (Injection, bendamustine hydrochloride (Vivimusta), 1 mg)
- J9058 (Injection, bendamustine hydrochloride (Apotex), 1 mg)
- J9059 (Injection, bendamustine hydrochloride (Baxter), 1 mg)

Prescribing Restriction(s)

Frequency of billing equals

CLL: Days 1 and 2 of a 28-day cycle, up to 6 cycles

NHL: Days 1 and 2 of a 21-day cycle, up to 8 cycles»

Bevacizumab

Policy for intravitreal bevacizumab (HCPCS code J9035) is located in the *Ophthalmology* section of the appropriate Part 2 manual.

Bevacizumab is a vascular endothelial growth factor-specific angiogenesis inhibitor and is reimbursable for the treatment of:

- Metastatic breast cancer, with paclitaxel for treatment of patients who have not received chemotherapy for metastatic HER2-negative breast cancer
- Unresectable, locally advanced, recurrent or metastatic non-squamous, non-small cell lung cancer, with carboplatin and paclitaxel for first line treatment
- Metastatic colorectal cancer, with intravenous five fluorouacil-based chemotherapy for first- or second-line treatment
- Glioblastoma multiforme, as a single agent for patients with progressive disease following prior therapy
- Metastatic renal cell carcinoma with interferon alpha
- Cervical cancer, in combination with paclitaxel and cisplatin or paclitaxel and topotecan in persistent, recurrent, or metastatic disease
- Platinum-resistant recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, in combination with paclitaxel, pegylated liposomal doxorubicin or topotecan

Dosage

The recommended dosage for bevacizumab varies depending upon the disease being treated.

Required Codes

Bevacizumab is reimbursable only with one of the following ICD-10-CM diagnosis codes:

C18.0 thru C20	E09.3519
C21.2	E10.3311 thru E10.3313
C21.8	E10.3319
C34.00 thru C34.92	E10.3411 thru E10.3413
C48.1 thru C48.2	E10.3419
C50.011 thru C50.929	E10.3511 thru E10.3513
C53.0 thru C53.9	E10.3519
C56.1 thru C57.4	E11.311
C64.1 thru C64.9	E11.3211 thru E11.3213
C71.0 thru C71.9	E11.3219
E08.311	E11.3311 thru E11.3313
E08.3211 thru E08.3213	E11.3319
E08.3219	E11.3411 thru E11.3413
E08.3311 thru E08.3313	E11.3419
E08.3319	E11.3511 thru E11.3513
E08.3411 thru E08.3413E08.3419	E11.3519
E08.3511 thru E08.3513	E13.311
E08.3519	E13.3211 thru E13.3213
E09.311	E13.3219
E09.3211 thru E09.3213	E13.3311 thru E13.3313
E09.3219	E13.3319
E09.3311 thru E09.3313	E13.3411 thru E13.3413
E09.3319	E13.3419
E09.3411 thru E09.3413	E13.3511 thru E13.3513
E10.311	E13.3519
E10.3211 thru E10.3213	H34.8110 thru H34.8112
E10.3219	H34.8120 thru H34.8122
E09.3419	H34.8130 thru H34.8132
E09.3511 thru E09.3513	H34.8190 thru H34.8192

Required Codes (continued)

H34.8310 thru H34.8312	H35.3230 thru H35.3233
H34.8320 thru H34.8322	H35.3290 thru H35.3293
H34.8330 thru H34.8332	H35.351 thru H35.353
H34.8390 thru H34.8392	H35.359
H35.3210 thru H35.3213	H35.81
H35.3220 thru H35.3223	

Billing

HCPCS code J9035 (injection, bevacizumab, 10 mg)

One (1) unit equals 10 mg

Bevacizumab is packaged in 100 mg and 400 mg vials, and it may be necessary to discard the unused portion of a vial. Providers may bill for a quantity equal to the amount given to the patient plus the amount wasted. Providers must specify the amount wasted in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim.

Bevacizumab-adcd (Vegzelma)

Bevacizumab products bind VEGF and prevent the interaction of VEGF to its receptors (Flt-1 and KDR) on the surface of endothelial cells. The interaction of VEGF with its receptors leads to endothelial cell proliferation and new blood vessel formation in in vitro models of angiogenesis. Administration of bevacizumab to xenotransplant models of colon cancer in nude (athymic) mice caused reduction of microvascular growth and inhibition of metastatic disease progression.

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

TAR Criteria

Vegzelma is considered medically necessary when all of the following criteria are met:

- Must be used for FDA-approved indications and dosages
- Patient must be 18 years of age or older
- Vegzelma will be used as a treatment for one of the following conditions:
 - **A. Cervical cancer, persistent/recurrent/metastatic**
 - ❖ Treatment of persistent, recurrent, or metastatic cervical cancer (in combination with paclitaxel and either cisplatin or topotecan)
 - ❖ Treatment of persistent, recurrent, or metastatic cervical carcinoma (in combination with pembrolizumab, paclitaxel [conventional], and either cisplatin or carboplatin) – (plus or minus individualized radiation therapy and/or palliative care)
 - **B. Colorectal cancer, metastatic**
 - ❖ First- or second-line treatment of metastatic colorectal cancer (CRC) (in combination with fluorouracil-based chemotherapy)
 - ❖ Second-line treatment of metastatic CRC (in combination with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy) after progression on a first-line treatment containing bevacizumab
 - ❖ Drug is not being used for the adjuvant treatment of colon cancer
 - **C. Glioblastoma, recurrent:**
 - ❖ Treatment of recurrent glioblastoma in adults
 - **D. Non-small cell lung cancer, nonsquamous:**
 - ❖ First-line treatment of unresectable, locally advanced, recurrent or metastatic nonsquamous non-small cell lung cancer (in combination with carboplatin and paclitaxel)
 - **E. Ovarian (epithelial), fallopian tube, or primary peritoneal cancer:**
 - ❖ Stage III or IV disease, following initial surgical resection: Treatment of stage III or IV epithelial ovarian, fallopian tube, or primary peritoneal cancer following initial surgical resection (in combination with carboplatin and paclitaxel, followed by single-agent bevacizumab)
 - ❖ Platinum-resistant recurrent: Treatment of platinum-resistant recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer (in combination with paclitaxel, doxorubicin [liposomal], or topotecan) in patients who received no more than two prior chemotherapy regimens

- ❖ Platinum-sensitive recurrent: Treatment of platinum-sensitive recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer (in combination with carboplatin and paclitaxel or with carboplatin and gemcitabine and then followed by single-agent bevacizumab)

– **F. Renal cell carcinoma, metastatic:**

- ❖ Treatment of metastatic renal cell carcinoma (in combination with interferon alfa)

Initial authorization is for 6 months.

Continued Therapy

- Patient continues to meet initial approval criteria.
- Patient has experienced positive clinical response such as stabilization of disease or decrease in tumor size or spread.
- Patient has absence of unacceptable toxicity such as gastrointestinal perforations and fistula, severe arterial thromboembolic events (ATE), grade four venous thromboembolic events (VTE), hypertensive crisis or hypertensive encephalopathy, posterior reversible encephalopathy syndrome (PRES), nephrotic syndrome (less than 2g of proteins in urine), severe infusion-related reactions, congestive heart failure (CHF), etc.

Reauthorization is for 12 months.

Age Limits

Must be 18 years of age or older.

Billing

HCPCS code: Q5129 (injection, bevacizumab-adcd [vegzelma], biosimilar, 10 mg)

Bevacizumab-awwb (Mvasi)

Bevacizumab products bind human vascular endothelial growth factor (VEGF) and prevent the interaction of VEGF to its receptors (Flt-1 and KDR) on the surface of endothelial cells. The interaction of VEGF with its receptors leads to endothelial cell proliferation and new blood vessel formation in in vitro models of angiogenesis. Administration of bevacizumab products to xenotransplant models of colon cancer in nude (athymic) mice caused reduction of microvascular growth and inhibition of metastatic disease progression.

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

TAR Requirement

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Age Limits

Must be 18 years of age or older

Billing

HCPCS code Q5107 (injection, bevacizumab-awwb, biosimilar, [mvasi] 10 mg)

One (1) unit of Q5107 equals 10 mg of bevacizumab-awwb

Bevacizumab-bvzr (Zirabev)

Bevacizumab-bvzr, a recombinant humanized monoclonal IgG1 antibody, binds to vascular endothelial growth factor (VEGF) and inhibits the interaction of VEGF to Flt1 and KDR receptors on the surface of endothelial cells. In the process, it leads to the proliferation of endothelial cells and formation of new blood vessels.

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

TAR Requirement

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Age Limits

Must be 18 years of age or older

Billing

HCPCS code Q5118 (injection, bevacizumab-bvcr, biosimilar [Zirabev], 10 mg)

Prescribing Restrictions

Frequency of billing equals every 14 days

Maximum billing units equals 2,280 mg equals 228 units

Bevacizumab-maly (Alymsys®)

Bevacizumab products bind vascular endothelial growth factor (VEGF) and prevent the interaction of VEGF to its receptors Flt-1 and KDR (fms-like tyrosine kinase receptor 1 [Flt-1] and Kinase insert domain receptor [KDR]) on the surface of endothelial cells. The interaction of VEGF with its receptors leads to endothelial cell proliferation and new blood vessel formation in in vitro models of angiogenesis. Administration of bevacizumab to xenotransplant models of colon cancer in nude (athymic) mice caused reduction of microvascular growth and inhibition of metastatic disease progression.

Indications

All FDA-approved indications.

Dosage

FDA-approved dosages.

TAR Requirement

An approved Treatment Authorization Request (TAR) is required for reimbursement.

TAR Criteria

Alymsys is considered medically necessary when all of the following criteria are met:

- Must be used for FDA-approved indications and dosages
- Patient must be 18 years of age or older
- Alymsys will be used as a treatment for one the following:
 - A. Cervical cancer, persistent/recurrent/metastatic
 - Treatment of persistent, recurrent, or metastatic cervical cancer (in combination with paclitaxel and either cisplatin or topotecan)
 - Treatment of persistent, recurrent, or metastatic cervical carcinoma (in combination with pembrolizumab, paclitaxel [conventional], and either cisplatin or carboplatin) – (plus or minus individualized radiation therapy and/or palliative care)
 - B. Colorectal cancer, metastatic
 - First- or second-line treatment of metastatic colorectal cancer (CRC) (in combination with fluorouracil-based chemotherapy)
 - Second-line treatment of metastatic CRC (in combination with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy) after progression on a first-line treatment containing bevacizumab
 - Drug is not being used for the adjuvant treatment of colon cancer

- C. Glioblastoma, recurrent:
 - Treatment of recurrent glioblastoma in adults
- D. Non-small cell lung cancer, nonsquamous:
 - First-line treatment of unresectable, locally advanced, recurrent or metastatic nonsquamous non-small cell lung cancer (in combination with carboplatin and paclitaxel)
- E. Ovarian (epithelial), fallopian tube, or primary peritoneal cancer:
 - Stage III or IV disease, following initial surgical resection: Treatment of stage III or IV epithelial ovarian, fallopian tube, or primary peritoneal cancer following initial surgical resection (in combination with carboplatin and paclitaxel, followed by single-agent bevacizumab)
 - Platinum-resistant recurrent: Treatment of platinum-resistant recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer (in combination with paclitaxel, doxorubicin [liposomal], or topotecan) in patients who received no more than two prior chemotherapy regimens
 - Platinum-sensitive recurrent: Treatment of platinum-sensitive recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer (in combination with carboplatin and paclitaxel or with carboplatin and gemcitabine and then followed by single-agent bevacizumab)
- F. Renal cell carcinoma, metastatic:
 - Treatment of metastatic renal cell carcinoma (in combination with interferon alfa)

Initial authorization is for six months.

Continued therapy:

- Patient continues to meet initial approval criteria
- Patient has experienced positive clinical response such as stabilization of disease or decrease in tumor size or spread.

Patient has absence of unacceptable toxicity such as gastrointestinal perforations and fistula, severe arterial thromboembolic events (ATE) grade four venous thromboembolic events (VTE), hypertensive crisis or hypertensive encephalopathy, posterior reversible encephalopathy syndrome (PRES), nephrotic syndrome (less than 2g of proteins in urine), severe infusion-related reactions, congestive heart failure (CHF), etc.

Reauthorization is for 12 months.

Age Limits

Must be 18 years of age or older.

Billing

HCPCS code Q5126 (injection, bevacizumab-maly, biosimilar, (alymsys), 10 mg).

Blinatumomab (Blincyto®)

Blinatumomab is a bispecific CD19-directed CD3 T-cell engager that binds to CD19 expressed on the surface of cells of B-lineage origin and CD3 expressed on the surface of T-cells. It activates endogenous T-cells and mediates the formation of a synapse between the T-cell and the tumor cell, upregulation of cell adhesion molecules, production of cytolytic proteins, release of inflammatory cytokines and proliferation of T-cells, which results in redirected lysis of CD19-positive cells.

Indications

All FDA-approved indications.

Dosage

FDA-approved dosages.

TAR Requirement

No approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Blincyto REMS:

Blincyto must be prepared and administered based on the Risk Evaluation and Mitigation Strategy (REMS) requirements defined by the FDA. The goals of the Blincyto REMS are to mitigate the risk of cytokine release syndrome which may be life-threatening or fatal; the risk of neurological toxicities which may be severe, life-threatening, or fatal; and the risk of preparation and administration errors associated with use of Blincyto by:

- Informing healthcare providers about the risk of cytokine release syndrome which may be life-threatening or fatal
- Informing healthcare providers about the risk of neurological toxicities which may be severe, life-threatening, or fatal
- Informing pharmacists, who will prepare and dispense Blincyto, and nurses, who will administer Blincyto, about the risk of preparation and administration errors associated with use of Blincyto

Billing

HCPCS code J9039 (injection, blinatumomab, 1 microgram)

Bortezomib

Bortezomib is a reversible inhibitor of the chymotrypsin-like activity of the 26S proteasome in mammalian cells. The 26S proteasome is a large protein complex that degrades ubiquitinated proteins. The ubiquitin-proteasome pathway plays an essential role in regulating the intracellular concentration of specific proteins, thereby maintaining homeostasis within cells. Inhibition of the 26S proteasome prevents this targeted proteolysis, which can affect multiple signaling cascades within the cell. This disruption of normal homeostatic mechanisms can lead to cell death. Experiments have demonstrated that bortezomib is cytotoxic to a variety of cancer cell types in vitro. Bortezomib causes a delay in tumor growth in vivo in nonclinical tumor models, including multiple myeloma.

Indications

All FDA-approved indications.

Dosage

FDA-approved dosages.

TAR Requirement

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Age Limits

«Must be 18 years of age or older (Hospira, Dr Reddy's, Fresenius Kabi and Maia brands).»

No age restrictions on HCPCS code J9041.

Billing

HCPCS codes:

J9041 (injection, bortezomib [velcade], 0.1 mg).

J9046 (injection, bortezomib, [dr. reddy's], not therapeutically equivalent to J9041, 0.1 mg)

J9048 (injection, bortezomib [fresenius kabi], not therapeutically equivalent to J9041, 0.1 mg).

J9049 (injection, bortezomib [hospira], not therapeutically equivalent to J9041, 0.1 mg)

«J9051 (injection, bortezomib [maia], not therapeutically equivalent to J9041, 0.1 mg)»

Required Codes

C83.10 thru C83.19, C90.00 thru C90.02.

Brentuximab Vedotin (Adcetris)

Brentuximab vedotin is a CD30-directed antibody-drug conjugate (ADC) consisting of three components: (1) the chimeric IgG1 antibody cAC10, specific for human CD30, (2) the microtubule disrupting agent monomethyl auristatin E (MMAE), and (3) a protease-cleavable linker that covalently attaches MMAE to cAC10. Nonclinical data suggest that the anticancer activity of brentuximab vedotin is due to the binding of the ADC to CD30-expressing cells, followed by internalization of the ADC-CD30 complex, and the release of MMAE via proteolytic cleavage. Binding of MMAE to tubulin disrupts the microtubule network within the cell, subsequently inducing cell cycle arrest and apoptotic death of the cells.

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

TAR Criteria

Adcetris is considered medically necessary when all of the following criteria are met:

- Must be used for FDA approved indications and dosing regimens
- Recipient must be 18 years of age or older
- Brentuximab Vedotin is being used for one of the following diagnoses and treatments:
 - **Anaplastic large cell lymphoma (primary cutaneous), relapsed:** Treatment of primary cutaneous anaplastic large cell lymphoma in recipients who have received prior systemic therapy
 - **Anaplastic large cell lymphoma (systemic), previously untreated:** Treatment of previously untreated systemic anaplastic large cell lymphoma (in combination with cyclophosphamide, doxorubicin, and prednisone)
 - **Anaplastic large cell lymphoma (systemic), relapsed:** Treatment of systemic anaplastic large cell lymphoma after failure of at least one prior multiagent chemotherapy regimen
 - **Hodgkin lymphoma, previously untreated:** Treatment of previously untreated stage III or IV classical Hodgkin lymphoma (in combination with doxorubicin, vinblastine, and dacarbazine)

- **Hodgkin lymphoma, relapsed or refractory:** Treatment of classical Hodgkin lymphoma after failure of at least 2 prior multiagent chemotherapy regimens (in recipients who are not autologous hematopoietic stem cell transplant [HSCT] candidates) or after failure of autologous HSCT
- **Hodgkin lymphoma, consolidation (post-autologous hematopoietic stem cell transplantation):** Treatment of classical Hodgkin lymphoma in recipients at high risk of relapse or progression as post-autologous HSCT consolidation
- **Mycosis fungoides, relapsed:** Treatment of CD30-expressing mycosis fungoides in recipients who have received prior systemic therapy
- **Peripheral T-cell lymphoma, CD30-expressing, previously untreated:** Treatment of previously untreated CD30-expressing peripheral T-cell lymphomas (PTCL), including angioimmunoblastic T-cell lymphoma and PTCL not otherwise specified (in combination with cyclophosphamide, doxorubicin, and prednisone)

Initial Authorization is for 12 months.

Renewal Criteria

- Recipient continues to meet initial approval criteria
- Recipient has experienced positive clinical response defined by stabilization of disease or decrease in tumor size or spread
- Recipient does not have unacceptable toxicity from the drug such as progressive multifocal leukoencephalopathy, peripheral neuropathy, anaphylaxis, infusion reactions, neutropenia, etc.

Reauthorization is for 12 months.

Age Limits

Must be 18 years of age or older.

Billing

HCPCS code J9042 (injection, brentuximab vedotin, 1 mg)

Prescribing Restrictions

Frequency of billing equals 180 mg/180 units every three weeks or 120 mg/120 units every two weeks

Maximum billing unit(s) equals 180 mg/180 units

Brexucabtagene autoleucel (Tecartus™)

Brexucabtagene autoleucel, a CD19 (Cluster of Differentiation 19)-directed genetically modified autologous T cell immunotherapy, binds to CD19-expressing cancer cells and normal B cells. Studies demonstrated that following anti-CD19 CAR T cell engagement with CD19-expressing target cells, the CD28 and CD3-zeta co-stimulatory domains activate downstream signaling cascades that lead to T cell activation, proliferation, acquisition of effector functions, and secretion of inflammatory cytokines and chemokines. This sequence of events leads to killing of CD19-expressing cells.

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement

TAR Criteria

Tecartus is considered medically necessary when all of the following criteria are met:

Universal Criteria

- Must be used for FDA-approved indications and dosages.
- Patient must be 18 years of age or older.
- Must be prescribed by or in consultation with an oncologist or a hematologist.
- Must be administered in a health care facility registered with the Risk Evaluation and Mitigation Strategy (REMS) called the YESCARTA and TECARTUS REMS Program.
- Patient does not have active or serious infection or inflammatory disorders
- Patient has not previously received treatment with a CAR T-cell immunotherapy
- Outpatient administration is restricted to Hospital Outpatient Services only

Mantle Cell Lymphoma (MCL)

- Patient must meet the universal criteria above
- Patient must have a diagnosis of relapsed or refractory mantle cell lymphoma (MCL)

- Patient previously received anthracycline- or bendamustine-containing chemotherapy, an anti-CD20 antibody (for example, rituximab), and a Bruton tyrosine kinase inhibitor (BTKi) (for example, acalabrutinib, ibrutinib, zanubrutinib)
- Patient had disease progression after their last regimen or refractory disease to their most recent therapy
- Patient must have adequate bone marrow, cardiac, pulmonary, renal, and organ functions
- Patient does not have the following:
 - Prior allogeneic hematopoietic stem cell transplant (HSCT)
 - Detectable cerebrospinal fluid malignant cells or brain metastases
 - History of central nervous system (CNS) lymphoma or CNS disorders

Relapsed or Refractory B-Precursor ALL

- Patient must meet the universal criteria above
- Patient must have a diagnosis of relapsed or refractory B-precursor Acute Lymphoblastic Leukemia (ALL) defined as one of the following:
 - Primary refractory disease
 - First relapse if first remission is 12 months or less
 - Relapsed or refractory disease after two or more lines of systemic therapy
 - Relapsed or refractory disease at least 100 days after allogeneic stem cell transplantation (HSCT); OR
- A patient with Philadelphia chromosome positive (Ph+) disease is eligible if one of the following is met:
 - Patient is intolerant to tyrosine kinase inhibitor (TKI) therapy
- Patient has relapsed/refractory disease despite treatment with at least two different TKIs

- Patient has adequate renal, hepatic, pulmonary and cardiac function
- Patient has an ECOG performance status of zero or one
- Patient does not have the following:
 - Central nervous system (CNS) abnormalities
 - Active graft-vs-host disease

Initial Authorization is for three months (one dose only)

Reauthorization is not approvable.

Yescarta and Tecartus REMS:

The goals of the Yescarta and Tecartus REMS are to mitigate the risks of cytokine release syndrome (CRS) and neurological toxicities by:

1. Ensuring that hospitals and their associated clinics that dispense Yescarta and/or Tecartus are specially certified and have on-site, immediate access to tocilizumab
2. Ensuring those who prescribe, dispense, or administer Yescarta and/or Tecartus are aware of how to manage the risks of CRS and neurological toxicities

Age Limits

Must be 18 years of age or older.

Billing

HCPCS code Q2053, (Brexucabtagene autoleucel, up to 200 million autologous anti-CD19 CAR positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic dose).

«One unit of Q2053 equals a single infusion of up to 200 million autologous anti-CD19 CAR-positive viable T cells.»

Administration code: CPT code 96413 (Chemotherapy administration, intravenous infusion technique; up to 1 hour single, single or initial substance/drug).

Important Instructions for Billing

Due to systems limitations, providers are to take the following steps when submitting claims.

For Tecartus:

- Submit and receive back an approved TAR

Bill using Q2053 (Brexucabtagene autoleucel, up to 200 million autologous anti-CD19 CAR positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose)

- Completion of claim forms:
 - Claims are restricted to hospital outpatient services. Note that claims from pharmacies and clinics will be denied.
 - Outpatient claims may be billed by paper claim using *UB-04* or electronically using 837I.
 - Providers must submit one service line on the TAR request and enter “5” in the Units box.
 - On the 837I or *UB-04* claim form, provider must submit one claim line to represent one service:
 - ❖ Claims submitted with more than one claim line will be denied:
 - Provider must submit an invoice for reimbursement.
 - This process will ensure that the total reimbursement paid for the quantity of five is no more than the paid price on the provider submitted invoice.
 - Tecartus must be billed on its own with no other drug or biological.
- For instructions regarding physician claim form completion, refer to the [Forms](#) page on the [Medi-Cal Providers website](#), forms section for completion of 837I and [UB-04 claim forms](#).
- Providers may bill separately for the administration (infusion) of the CAR-T cell using CPT code 96413.

«Required ICD-10-CM Diagnosis Codes»

«C83.10 through C83.19; C91.00 and C91.02»

Prescribing Restrictions

Frequency of billing equals one dose only. No repeat authorization.

«Cabazitaxel»

Cabazitaxel is an antineoplastic agent belonging to the taxane class. Cabazitaxel is a microtubule inhibitor that binds to tubulin and promotes its assembly into microtubules while simultaneously inhibiting disassembly. This leads to the stabilization of microtubules, which results in the inhibition of mitotic and interphase cellular functions.

Indications

All FDA-approved indications.

Dosage

TAR Requirement

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Age Limits

«Must be 18 years of age or older.»

Billing

«HCPCS codes:

J9043 (injection, cabazitaxel, 1 mg) (Jevtana)

J9064 (injection, cabazitaxel [sandoz], not therapeutically equivalent to J9043, 1 mg)»

One billing unit equals 1 mg

«Required ICD-10 Diagnosis Code»

C61

Calaspargase pegol-mknl (ASPARLAS™)

L-asparaginase is an enzyme that catalyzes the conversion of the amino acid L-asparagine into aspartic acid and ammonia. The pharmacological effect of ASPARLAS is thought to be based on the killing of leukemic cells due to depletion of plasma asparagine. Leukemic cells with low expression of asparagine synthetase have a reduced ability to synthesize asparagine, and therefore depend on an exogenous source of asparagine for survival.

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement

TAR Criteria

The TAR must include clinical documentation that demonstrates all of the following:

- Must be used for all FDA-approved indications and dosages
- Patient must be 1 month to 21 years old
- Patient must have a diagnosis of acute lymphoblastic leukemia
- Must be prescribed by or in consultation with an oncologist or a hematologist
- Must be used in conjunction with multi-agent chemotherapy
- Patient must not have a history of serious hypersensitivity reactions with pegylated L-asparaginase therapy

Initial authorization is for 12 months.

Continued Therapy

- Patient has disease stabilization or improvement as evidenced by a complete response [CR] (i.e., morphologic, cytogenetic or molecular complete response CR), complete hematologic response or a partial response by CBC, bone marrow cytogenetic analysis, QPCR, or FISH
- Patient has absence of unacceptable toxicity from drug such as hypersensitivity reactions, serious thrombotic events, severe hemorrhage, severe hepatotoxicity, pancreatitis, etc.

Reauthorization is for 12 months.

Age Limits

Must be 1 month to 21 years old

Billing

HCPCS code: J9118 (Injection, calaspargase pegol-mknl, 10 units)

Suggested ICD 10 Diagnosis Codes

C83.50 thru C83.59: Lymphoblastic (diffuse) lymphoma

C91.00 thru C91.02: Acute lymphoblastic leukemia

Note: Asparlas is available through the following specialty distributor: Cardinal Health™

New customers: please call 866-476-1340

Online Orders: <https://orderexpress.cardinalhealth.com/> or
<https://specialtyonline.cardinalhealth.com/>

Carboplatin

Carboplatin, 50 mg (HCPCS code J9045), a platinum-containing chemotherapeutic agent, is reimbursable to treat the following:

Testicular cancer	Breast cancer
Ovarian cancer	Cancer of the esophagus
Bladder cancer	Cancer of the nasal cavity
Adrenal gland cancer	Wilms' tumor
Lung cancer (small-cell and non-small cell)	Cancer without specification of the primary site
Cancer of the cervix	Retinoblastoma
Endometrial cancer	Brain cancer
Neuroblastoma	Cancer of the skin
Osteogenic sarcoma	Hodgkin lymphoma
Head, face and neck cancer	Non-Hodgkin lymphoma

CPT code 96413 (chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug) may be billed in conjunction with carboplatin code J9045.

Place of Service: Outpatient

Carboplatin is used as an alternative to cisplatin in the outpatient setting due to its lower gastrointestinal toxicity and short infusion time. No pre or post-treatment hydration or forced diuresis is required, as with cisplatin.

Dosage

The maximum dose is for carboplatin is 20 units. Doses in excess of 20 units will be allowed when medically justified, such as dose based on age, sex, renal function, weight, height, etc., Carboplatin Area Under Curve (AUC) Calculation.

Billing

HCPCS code J9045 (injection, carboplatin, 50 mg)

Carfilzomib

Carfilzomib is a tetrapeptide epoxyketone proteasome inhibitor that irreversibly binds to the N-terminal threonine-containing active sites of the 20S proteasome, the proteolytic core particle within the 26S proteasome. Carfilzomib had antiproliferative and proapoptotic activities *in vitro* in solid and hematologic tumor cells.

Indications

Carfilzomib is indicated for the treatment of multiple myeloma.

Combination Therapy:

- In combination with dexamethasone or with lenalidomide plus dexamethasone for the treatment of patients with relapsed or refractory multiple myeloma who have received one to three lines of therapy

Monotherapy:

- As a single agent for the treatment of patients with relapsed or refractory multiple myeloma who have received one or more lines of therapy

Limited to patients 18 years of age and older.

Dosage

The recommended dosing regimens for monotherapy and combination therapy differ. Please refer to the appropriate literature for the regimens.

Required Codes

Carfilzomib is reimbursable when billed with one of the following ICD-10-CM diagnosis codes:

C90.00	C90.20
C90.02	C90.22
C90.10	C90.30
C90.12	C90.32

Billing

HCPCS code J9047 (injection, carfilzomib, 1 mg)

Cemiplimab-rwlc (Libtayo)

Cemiplimab-rwlc is a monoclonal antibody that targets checkpoint inhibitor PD-1 (programmed death 1) and blocks its interaction with PD-L1 and PD-L2, releasing the PD-1 pathway-mediated inhibition of the immune response, including antitumor response, thereby decreasing tumor growth. Binding of the PD-1 ligands and PD-L1 and PD-L2, to the PD-1 receptor found on T cells, inhibits T-cell proliferation and cytokine production.

TAR Requirement

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

Age Limits

Must be 18 years of age or older

Billing

HCPCS code J9119 (injection, cemiplimab-rwlc, 1 mg)

Prescribing Restrictions

Frequency of billing equals every 21 days

Maximum billing unit(s) equals 350 mg equals 350 units

Cetuximab

Cetuximab is reimbursable for the treatment of locally or regionally advanced squamous cell carcinoma of the head and neck, and metastatic colorectal carcinoma.

Dosage

The recommended dosing schedule for intravenous infusion of cetuximab is an initial dose of 400 mg/m², followed by 250 mg/m² every week or 500 mg/m² every two weeks.

See additional billing information for cetuximab under panitumumab in the *Chemotherapy: Drugs P-Z* Policy section of this manual.

Required Codes

Cetuximab is reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes:

C00.0 thru C14.8

C30.0 thru C31.9

C18.0 thru C20

C32.0 thru C32.9

C21.2

C76.0

C21.8

Note: A California Children's Services/Genetically Handicapped Persons Program (CCS/GHPP) Service Authorization Request (SAR) overrides the preceding diagnostic restrictions.

Billing

HCPCS code J9055 (injection, cetuximab, 10 mg)

Ciltacabtagene autoleucel; cilta-cel (Carvykti™)

Carvykti is a BCMA-directed, genetically modified autologous T cell immunotherapy, which involves reprogramming a patient's own T cells with a transgene encoding a CAR (chimeric antigen receptor) that identifies and eliminates cells that express BCMA. The CARVYKTI CAR protein features two BCMA-targeting, single-domain antibodies designed to confer high avidity against human BCMA, a 4-1BB co-stimulatory domain and a CD3-zeta (CD3ζ) signaling cytoplasmic domain. Upon binding to BCMA-expressing cells, the CAR promotes T cell activation, expansion, and elimination of target cells.

Indications

All FDA-approved indications.

Dosage

FDA-approved dosages.

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

TAR Criteria

The TAR must include clinical documentation that demonstrates the following:

- Must be used for FDA-approved indications and dosages.
- Patient must be 18 years of age or older.
- Must be prescribed by or in consultation with an oncologist or a hematologist.
- Patient must have a diagnosis of relapsed or refractory multiple myeloma (RRMM).
- RRMM is histologically or cytologically confirmed according to International Myeloma Working Group (IMWG) criteria.
- Patient has received four or more myeloma treatment regimens including a proteasome inhibitor (for example, bortezomib, carfilzomib, ixazomib), an immunomodulatory agent (for example, lenalidomide, pomalidomide, thalidomide) and an anti-CD38 antibody (for example, daratumumab, daratumumab/hyaluronidase, isatuximab).

- Patient has an Eastern Cooperative Oncology Group (ECOG) performance status grade of zero or one
- Patient has no current or prior history of central nervous system (CNS) involvement or exhibits clinical signs of meningeal involvement of multiple myeloma
- Patient has left ventricular ejection fraction of 45 percent or more
- Patient has no active infection or inflammatory disorders
- Patient has not been previously treated with CAR-T therapy in RRMM
- Carvykti will not be used concurrently with another CAR-T therapy
- Carvykti must be administered at a healthcare facility certified by the manufacturer based on the Risk Evaluation and Mitigation Strategy (REMS) requirements defined by the FDA
- Outpatient administration is restricted to Hospital Outpatient Services only

Approval is for three months (one treatment only).

Reauthorization is not approvable.

REMS

- Due to the risk of cytokine release syndrome (CRS) and neurologic toxicities, Carvykti is available only through a restricted program under a REMS called the Carvykti REMS.
- Healthcare facilities that dispense and administer Carvykti must be enrolled and must comply with the REMS requirements.
- Certified healthcare facilities must ensure that healthcare providers who prescribe, dispense, or administer Carvykti are trained in the management of CRS and neurologic toxicities.

Age Limits

Must be 18 years of age or older.

Billing

HCPCS code Q2056 (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).

Administration code: CPT code 96413 (chemo administration, intravenous infusion; up to one hour, single or initial substance/drug).

Important Instructions for Billing

Due to systems limitations, providers are to take the following steps when submitting claims for Carvykti:

1. Submit and receive back an approved *Treatment Authorization Request (TAR)/Service Authorization Request (SAR)*.
2. Bill using Q2056.
3. Completion of claim forms:
 - Claims are restricted to hospital outpatient services. Note that claims from pharmacies and clinics will be denied
 - Outpatient claims may be billed by paper claim using *UB-04* or electronically using 837I
 - Providers must submit one (1) service line on the TAR/SAR request, and enter “5” in the *Units* box
 - On the 837I or *UB-04* claim form, providers must submit one claim line to represent one (1) service
 - ❖ Claims submitted with more than one claim line will be denied
 - Providers must submit an invoice for reimbursement
 - This process will ensure that the total reimbursement paid for the quantity of five (5) is no more than the paid price on the provider submitted invoice
 - Carvykti must be billed on its own with no other drug or biological

4. For instructions regarding physician claim form completion, refer to the [Forms](#) page on the [Medi-Cal Providers website](#), forms section for completion of 837I and [UB-04 claim forms](#).
5. Providers may bill separately for the administration (infusion) of the CAR-T cell using CPT code 96413

Required ICD-10 Diagnosis Codes

C90.00, C90.02

Prescribing Restriction(s)

Frequency of billing equals one dose/five units per lifetime

Maximum billing unit(s) equals one dose/five units

Cisplatin

Cisplatin is reimbursable when used as treatment of the following:

- Testicular and ovarian tumors
- Transitional cell bladder cancer
- Malignancies of the head and neck
- Small cell lung cancer
 - Undifferentiated
 - Lymphocyte-like
 - Oat cell type carcinomas
- Cervical carcinomas
 - Squamous cell
 - Metastatic
- Solid tumors in children where radiation or other chemotherapeutic agents are not appropriate
 - Osteosarcomas
 - Neuroblastomas
 - Germ cell tumors

Dosage

Maximum dosage is 250 mg (25 billing units); greater dosage allowed if documentation shows body surface area (BSA) is greater than 2.5 m².

Inpatient Services Requirements

This type of chemotherapy requires adequate hydration of the patient. If it is not possible to maintain hydration in an outpatient setting or if the patient has previously had severe reactions (such as nausea and vomiting), inpatient treatment may be required. If administration of cisplatin is the only reason for hospital admission, the Medi-Cal consultant may approve a short hospitalization (less than 24 hours) up to three times in a 30-day period.

Intraperitoneal Cisplatin Therapy for Ovarian Malignancy

Intraperitoneal cisplatin therapy for ovarian malignancy is reimbursable when re-exploration has shown that systemic therapy has failed, as indicated by persistence and/or recurrence of the disease. In most cases, the Medi-Cal consultant will authorize a one-day inpatient admission to permit adequate hydration prior to administration of the agent.

Normally, intraperitoneal catheters and shunts are established to permit instillation of the medication over an extended period.

Billing

HCPCS code J9060 (cisplatin, 10 mg)

Cladribine

Cladribine is a synthetic antineoplastic agent for intravenous (I.V.) administration.

Indications

Cladribine is used to treat patients with neoplastic conditions such as hairy cell leukemia.

Age

All ages

Dosage

The dose and frequency of cladribine administration varies based on the patient's age, treatment condition, and response to therapy. The dose may range from 0.09-1.4 mg/kg/day given by I.V. infusion from between 1 to 7 days per cycle.

Authorization

No *Treatment Authorization Request* (TAR) is generally required for reimbursement.

Billing

HCPCS code J9065 (injection, cladribine, per 1 mg)

One (1) unit of J9065 equals 1 mg of cladribine injection solution

Clofarabine

Clofarabine is indicated for the treatment of pediatric patients 1 to 21 years of age with relapsed or refractory acute lymphoblastic leukemia after at least two prior regimens.

Authorization

A *Treatment Authorization Request* (TAR) is required for reimbursement.

Dosage

The recommended pediatric dosage and schedule for clofarabine is 52 mg/m² administered by intravenous infusion over two hours daily for five consecutive days. Treatment cycles are repeated approximately every two to six weeks.

Billing

HCPCS code J9027 (injection, clofarabine, 1 mg)

Clofarabine may be billed in conjunction with CPT code 96415 (chemotherapy administration, intravenous infusion technique; one to eight hours).

«Colony Stimulating Factors

Colony stimulating factors (CSF) are any number of glycoproteins responsible for the proliferation, differentiation, and functional activation of hematopoietic progenitor cells; specific factors are named for the cell lines that they stimulate. CSFs include granulocyte colony-stimulating factor (G-CSF) and granulocyte-macrophage colony-stimulating factor (GM-CSF). Treatment with CSFs can help the blood-forming tissue recover from the effects of chemotherapy and radiation therapy.

The following colony stimulating factors are benefits of the Medi-Cal program:

- Eflapegrastim-xnst (Rovedon™)
- Filgrastim
- Filgrastim-aafi (Nivestym™)
- Filgrastim-ayow (Releuko®)
- Filgrastim-sndz
- Pegfilgrastim (Neulasta®)
- Pegfilgrastim-apgf (Nyvepria™)
- Pegfilgrastim-bmez (Ziextenzo)
- Pegfilgrastim-cbqv (Udenyca®)
- Pegfilgrastim-jmdb (Fulphila)
- Pegfilgrastim-fpgk (Stimufend®)
- Pegfilgrastim-pbbk (Fylnetra)

Eflapegrastim-xnst (Rovedon™)

Eflapegrastim-xnst is a recombinant human granulocyte growth factor that binds to G-CSF receptors on myeloid progenitor cells and neutrophils, triggering signaling pathways that control cell differentiation, proliferation, migration and survival.

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement»

«TAR Criteria

Rolvedon is considered medically necessary when all of the following criteria are met:

- Must be used for FDA-approved indications and dosages
- Patient must be 18 years of age or older
- Drug is being used for prophylaxis in patients with solid tumors or non-myeloid malignancy under one the following conditions:
 - Patient is receiving myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of greater than 20 percent
 - Patient is undergoing myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of 10 to 20 percent and at least one of the following risk factors for febrile neutropenia:
 - ❖ Older than 65 years of age receiving full dose intensity chemotherapy
 - ❖ History of recurrent febrile neutropenia from chemotherapy
 - ❖ Extensive prior exposure to chemotherapy
 - ❖ Previous exposure of pelvis, or other areas of large amounts of bone marrow, to radiation
 - ❖ Persistent neutropenia (ANC less than or equal to 1000/mm³)
 - ❖ Bone marrow involvement by tumor
 - ❖ Patient has a condition that can potentially increase the risk of serious infection (i.e., HIV/AIDS with low CD4 counts)
 - ❖ Recent surgery and/or open wounds
 - ❖ Poor performance status
 - ❖ Renal dysfunction (creatinine clearance less than 50 mL/min)
 - ❖ Liver dysfunction (elevated bilirubin more than 2.0 mg/dL)
 - ❖ Chronic immunosuppression in the post-transplant setting, including organ transplant
 - The patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment outcome

Initial authorization is for 6 months.

Reauthorization is for 6 months for patients who continue to meet the above criteria.

Age Limits

Must be 18 years of age or older»»

<<Billing

HCPCS code: J1449, (Injection, eflapegrastim-xnst, 0.1 mg)

Prescribing Restriction(s)

Frequency of billing is 13.2 mg/132 units

Maximum billing unit(s) is 13.2 mg/132 units once per chemotherapy cycle>>

Filgrastim

Filgrastim is a Medi-Cal benefit when used for patients with severe neutropenia.

Dosage

The specific dosage of filgrastim is variable depending on which condition or disease is being treated.

Required Codes

Filgrastim is reimbursable only with one of the following ICD-10-CM diagnosis codes:

C92.00	C92.90	D70.4 thru D70.9
C92.30	C92.A0	D72.819
C92.40	C92.Z0	Z48.290
C92.50	D46.0 thru D46.9	Z51.11
C92.60	D70.0 thru D70.1	Z94.81

Billing

HCPCS code J1442 (injection, filgrastim [g-csf], excludes biosimilars, 1 microgram).

When billing for more than 1,200 mcg, providers must document in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) on the claim or on an attachment that the patient weighs more than 100 kg.>>

«**Filgrastim-aafi (Nivestym™)**

Colony-stimulating factors are glycoproteins which act on hematopoietic cells by binding to specific cell surface receptors and stimulating proliferation, differentiation commitment, and some end-cell functional activation.

Endogenous G-CSF is a lineage-specific colony-stimulating factor that is produced by monocytes, fibroblasts, and endothelial cells. G-CSF regulates the production of neutrophils within the bone marrow and affects neutrophil progenitor proliferation, differentiation, and selected end-cell functions (including enhanced phagocytic ability, priming of the cellular metabolism associated with respiratory burst, antibody-dependent killing, and the increased expression of some cell surface antigens). G-CSF is not species-specific and has been shown to have minimal direct in vivo or in vitro effects on the production or activity of hematopoietic cell types other than the neutrophil lineage.

Indications

All FDA-approved indications

Authorization

No *Treatment Authorization Request* (TAR) is required for reimbursement

Suggested ICD-10 Diagnosis Codes

D70.0, D70.1, D70.4, D70.8, D70.9 or Z51.11

Billing

HCPCS code Q5110 (injection, filgrastim-aafi, biosimilar [Nivestym], 1 mcg)

Filgrastim-ayow (Releuko®)

Filgrastim-ayow is a filgrastim biosimilar.

Filgrastim is a granulocyte colony-stimulating factor (G-CSF) produced by recombinant DNA technology. G-CSFs stimulate the production, maturation, and activation of neutrophils to increase both their migration and cytotoxicity.

Indication

All FDA-approved indications

Dosage

FDA-approved dosages

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement»

«TAR Criteria

Releuko is considered medically necessary when all of the following criteria are met:

- Must be for FDA- approved indications and dosages
- It is being prescribed for ONE of the following conditions:
 - Patient has nonmyeloid malignancy and is receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever and Releuko is being used to decrease the incidence of infection, as manifested by febrile neutropenia
 - Patient has acute myeloid leukemia (AML) and Releuko is being used to reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment
 - Patient has nonmyeloid malignancy and is undergoing myeloablative chemotherapy followed by bone marrow transplantation (BMT) and Releuko is being used to reduce the duration of neutropenia and neutropenia-related clinical sequelae, e.g., febrile neutropenia
 - Patient has symptomatic congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia and Releuko is being used to reduce the incidence and duration of sequelae of severe neutropenia, (e.g., fever, infections, oropharyngeal ulcers)
- Must not be used in combination with other granulocyte colony-stimulating factors (G-CSF) such as Neupogen, Granix, Zarxio, Nivestym, etc.

Initial approval is for six months.

Continued therapy

Patient continues to meet initial approval requirements.

Reauthorization is for six months.

Billing

HCPCS code Q5125 (injection, filgrastim-ayow, biosimilar, [releuko], 1 microgram)»»

«Filgrastim-sndz

Filgrastim-sndz is a leukocyte growth factor for intravenous (IV) or subcutaneous (SQ) administration. Filgrastim-sndz is biosimilar to filgrastim.

Indications

Filgrastim-sndz is used to enhance neutrophil production for the following indications:

- Non-myeloid malignancies in patients receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever.
- Acute myeloid leukemia (AML) in patients receiving induction or consolidation chemotherapy.
- Non-myeloid malignancies in patients receiving myeloablative chemotherapy prior to a bone marrow transplant.
- Mobilization of autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis in patients receiving cell therapy.
- Severe chronic neutropenia in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia.

Dosage

The recommended dose of filgrastim-sndz varies depending on the treatment indication.

Age

All ages

Authorization

No *Treatment Authorization Request* (TAR) is generally required for reimbursement.

Required Codes

One of the following ICD-10 CM diagnosis codes is required for reimbursement:

- D70.0 (Congenital agranulocytosis)
- D70.1 (Agranulocytosis secondary to cancer chemotherapy)
- D70.4 (Cyclic neutropenia)
- D70.8 (Other neutropenia)
- D70.9 (Neutropenia, unspecified)
- Z51.11 (Encounter for antineoplastic chemotherapy)>>

<<Billing

HCPCS code Q5101 (injection, filgrastim-sndz, biosimilar, [Zarxio], 1 microgram)
One (1) unit of Q5101 equals 1 microgram of filgrastim-sndz

Pegfilgrastim (Neulasta®)

Pegfilgrastim is a colony-stimulating factor that acts on hematopoietic cells by binding to specific cell surface receptors, thereby stimulating proliferation, differentiation, commitment and end cell functional activation.

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

TAR Requirements

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Billing

HCPCS code J2506 (injection, pegfilgrastim, excludes biosimilar, 0.5 mg).
One (1) unit equals 0.5 mg

Suggested ICD-10-CM Diagnosis Codes

D70.1, T45.1X5S, T45.1X5D, T45.1X5A, T45.1X5, T45.1X, T45.1

Prescribing Restriction(s)

Maximum billing unit(s) equals 6 mg/12 units

Pegfilgrastim-apgf (Nyvepria™), Pegfilgrastim-bmez (Ziextenzo)

Pegfilgrastim products are colony-stimulating factors that act on hematopoietic cells by binding to specific cell surface receptors, thereby stimulating proliferation, differentiation, commitment, and end cell functional activation.

Indications

All FDA-approved indications

Dosages

FDA-approved dosages>>

«TAR Requirement

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Billing

HCPCS codes:

- Q5122 (injection, pegfilgrastim-apgf [nyvepria], biosimilar, 0.5 mg)
- Q5120 (injection, pegfilgrastim-bmez, [ziextenzo], biosimilar, 0.5 mg)»

Prescribing Restrictions

Frequency of billing equals 6 mg/12 units per chemotherapy cycle

Maximum billing units equals mg/12 units

Pegfilgrastim-cbqv (Udenyca®), Pegfilgrastim- jmdb (Fulphila)

Pegfilgrastim products are colony-stimulating factors that act on hematopoietic cells by binding to specific cell surface receptors, thereby stimulating proliferation, differentiation, commitment, and end cell functional activation.»

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

TAR Requirement

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Required ICD-10-CM Diagnosis Codes

One of the following ICD-10-CM diagnosis codes is required for reimbursement:

- D70.1 (Agranulocytosis secondary to cancer chemotherapy)
- Z51.11 (Encounter for antineoplastic chemotherapy)»

<<Billing

HCPCS codes:

- Q5111 (Injection, pegfilgrastim-cbqv, [udenyca], biosimilar, 0.5 mg)
One (1) unit of Q5111 equals 0.5 mg of pegfilgrastim-cbqv
- HCPCS code Q5108 (injection, pegfilgrastim-jmdb, [fulphila], biosimilar, 0.5 mg)
One (1) unit of Q5108 = 0.5 mg of pegfilgrastim-jmdb

Pegfilgrastim-fpgk (Stimufend®), Pegfilgrastim-pbbk (Fylintra)

Pegfilgrastim products are colony-stimulating factors that act on hematopoietic cells by binding to specific cell surface receptors, thereby stimulating proliferation, differentiation, commitment, and end cell functional activation.

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

TAR Requirement

An approved *Treatment Authorization Requirement* (TAR) is required for reimbursement.

TAR Criteria

Stimufed is considered medically necessary when all of the following criteria are met:

- Must be used for FDA-approved indications and dosages
- Drug is being used for prophylaxis in patients with solid tumors or non-myeloid malignancy under one the following conditions:
 - Patient is receiving myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of greater than 20 percent
 - Patient is undergoing myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of 10 to 20 percent and at least one of the following risk factors for febrile neutropenia:
 - ❖ Ages older than 65 years receiving full dose intensity chemotherapy
 - ❖ History of recurrent febrile neutropenia from chemotherapy
 - ❖ Extensive prior exposure to chemotherapy»

- ❖ «Previous exposure of pelvis, or other areas of large amounts of bone marrow, to radiation
 - ❖ Persistent neutropenia (ANC less than or equal to 1000/mm³)
 - ❖ Bone marrow involvement by tumor
 - ❖ Patient has a condition that can potentially increase the risk of serious infection (i.e., HIV/AIDS with low CD4 counts)
 - ❖ Recent surgery and/or open wounds
 - ❖ Poor performance status
 - ❖ Renal dysfunction (creatinine clearance less than 50 mL/min)
 - ❖ Liver dysfunction (elevated bilirubin more than 2.0 mg/dL)
 - ❖ Chronic immunosuppression in the post-transplant setting, including organ transplant
- The patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment outcome

Initial authorization is for 6 months.

Reauthorization is for 6 months for patients who continue to meet the above criteria.

Billing

HCPCS codes:

- Q5127 (Injection, pegfilgrastim-fpgk (stimufend), biosimilar, 0.5 mg)
- Q5130 (Injection, pegfigrastim-pbbk (fynetra), biosimilar, 0.5 mg)

Prescribing Restriction(s)

Frequency of billing is 6 mg/12 units one per chemotherapy cycle

Maximum billing unit(s) is 6 mg/12 units»

Copanlisib

Copanlisib is a kinase inhibitor for intravenous (I.V.) administration.

Indications

Copanlisib is used to treat relapsed follicular lymphoma in adult patients who have received at least two prior systemic therapies.

Dosage

The recommended dose is 60 mg I.V. administered on treatment days 1, 8, and 15 of a 28-day treatment cycle on an intermittent schedule (three weeks on and one week off).

Age

18 years and older

Authorization

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

The TAR must include clinical documentation of the following:

- The service is medically necessary
- The patient has follicular lymphoma in relapse despite having received at least two systemic chemotherapy treatment regimens
- The physician's legible, complete, and signed treatment plan/order for copanlisib.

Billing

HCPCS code J9057 (injection, copanlisib, 1 mg)

One (1) unit of J9057 equals 1 mg of copanlisib injection solution

Cyclophosphamide

Cyclophosphamide, 100 mg (HCPCS code J9070) has a maximum dosage of 6.8 Gm. However, a dose in excess of 6.8 Gm is allowed with documentation of patient weight exceeding 136 kg.

Cyclophosphamide (Auromedics brand)

Cyclophosphamide is an alkylating agent that prevents cell division by cross-linking DNA strands and decreasing DNA synthesis. It is a cell cycle phase nonspecific agent.

Cyclophosphamide also possesses potent immunosuppressive activity. It is a prodrug that must be metabolized to active metabolites in the liver.

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

TAR Requirements

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

TAR Criteria

Cyclophosphamide is considered medically necessary when all of the following criteria are met:

- Must be used for FDA-approved indications and dosing regimens
- Patient has a diagnosis of one of the following malignant diseases:
 - Malignant lymphomas (Stages III and IV of the Ann Arbor staging system), Hodgkin's disease, lymphocytic lymphoma (nodular or diffuse), mixed-cell type lymphoma, histiocytic lymphoma, Burkitt's lymphoma
 - Multiple myeloma
 - Leukemias: chronic lymphocytic leukemia, chronic granulocytic leukemia (it is usually ineffective in acute blastic crisis), acute myelogenous and monocytic leukemia, acute lymphoblastic (stem-cell) leukemia (cyclophosphamide given during remission is effective in prolonging its duration)
 - Mycosis fungoides (advanced disease)
 - Neuroblastoma (disseminated disease)
 - Adenocarcinoma of the ovary
 - Retinoblastoma
 - Carcinoma of the breast

- Patient does not have hypersensitivity to cyclophosphamide
- Patient does not have urinary outflow obstruction

Approval is for 12 months

Billing

HCPCS code J9071 (injection, cyclophosphamide, [auromedics], 5 mg)

Daratumumab (Darzalex®)

Daratumumab is an IgG1k human monoclonal antibody (mAb) that binds to CD38 and inhibits the growth of CD38-expressing tumor cells by inducing apoptosis directly through Fc-mediated cross linking and by immune-mediated tumor cell lysis through complement-dependent cytotoxicity (CDC), antibody-dependent cell-mediated cytotoxicity (ADCC) and antibody-dependent cellular phagocytosis (ADCP). Myeloid-derived suppressor cells (MDSCs) and a subset of regulatory T-cells (CD38+Tregs) express CD38 and are susceptible to daratumumab-mediated cell lysis.

Indications

All FDA-approved indications

Dosage

FDA-approved dosages

TAR Requirement

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Age Limits

Must be 18 years of age or older.

Billing

HCPCS code J9145 (injection, daratumumab, 10 mg)

Suggested ICD-10-CM Diagnosis Codes

C90.00, C90.01, C90.02

Daratumumab and Hyaluronidase-fihj (Darzalex Faspro™)

Darzalex Faspro is a subcutaneous CD38-directed antibody. Daratumumab is an IgG1κ human monoclonal antibody directed against CD38. CD38 is a cell surface glycoprotein which is highly expressed on myeloma cells. By binding to CD38, daratumumab inhibits the growth of CD38-expressing tumor cells by inducing apoptosis directly through Fc mediated cross linking as well as by immune-mediated tumor cell lysis through complement dependent cytotoxicity, antibody dependent cell mediated cytotoxicity, and antibody dependent cellular phagocytosis. Hyaluronidase increases permeability of the subcutaneous tissue by depolymerizing hyaluronan. At the recommended dose, hyaluronidase acts locally and the effects are reversible; permeability of subcutaneous tissue is restored within 24 to 48 hours.

Indications

All FDA-approved indications.

Dosage

FDA-approved dosages.

TAR Requirement

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Age Limits

Must be 18 years of age or older.

Billing

HCPCS code J9144 (injection, daratumumab 10 mg and hyaluronidase-fihj)

Suggested ICD-10-CM Diagnosis Codes

C90.00, C90.01, C90.02

Prescribing Restrictions

Frequency of billing equals 1,800 mg/ 180 units every week

Maximum billing unit(s) equals 1,800 mg/ 180 units

Daunorubicin

Daunorubicin has antimitotic and cytotoxic activity through a number of proposed mechanisms of action. Daunorubicin forms complexes with DNA by intercalation between base pairs. It inhibits topoisomerase II activity by stabilizing the DNA-topoisomerase II complex, preventing the relegation portion of the ligation-relegation reaction that topoisomerase II catalyzes. Single strand and double strand DNA breaks result. Daunorubicin may also inhibit polymerase activity, affect regulation of gene expression, and produce free radical damage to DNA.

Indications

Daunorubicin is administered for the treatment of remission induction in acute nonlymphocytic leukemia (myelogenous, monocytic, erythroid) in adults and remission induction in acute lymphocytic leukemia in children and adults.

Dosage

The usual dose of daunorubicin is 45 mg/m² (90 mg or 9 units) and requires no authorization. If the dose administered is greater than 90 mg, an approved *Treatment Authorization Request* (TAR) documenting that the patient's body surface area is greater than 2.0 m² is required for reimbursement.

Billing

HCPCS code J9150 (injection, daunorubicin, 10 mg)

Daunorubicin/Cytarabine Liposome (Vyxeos)

Vyxeos (daunorubicin and cytarabine) liposome for injection is a liposomal formulation of daunorubicin and cytarabine at a fixed 1:5 molar ratio. The 1:5 molar ratio of daunorubicin:cytarabine has been shown to have synergistic effects at killing leukemia cells in vitro and in murine models. Daunorubicin has antimitotic and cytotoxic activity, which is achieved by forming complexes with DNA, inhibiting topoisomerase II activity, inhibiting DNA polymerase activity, affecting regulation of gene expression, and producing DNA-damaging free radicals. Cytarabine is a cell cycle phase-specific antineoplastic agent, affecting cells only during the S-phase of cell division. Cytarabine acts primarily through inhibition of DNA polymerase. Based on animal data, the liposomes enter and persist in the bone marrow, where they are taken up intact by bone marrow cells. In leukemia-bearing mice, the liposomes are taken up by leukemia cells to a greater extent than by normal bone marrow cells. After cellular internalization, liposomes undergo degradation releasing cytarabine and daunorubicin within the intracellular environment.

Indications

All FDA-approved indications.

Dosage

FDA-approved dosages.

TAR Requirement

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Age Limits

Must be 18 years of age or older.

Billing

HCPCS code J9153 (injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine)

One (1) unit of J9153 equals 1 mg of daunorubicin and 2.27 mg of cytarabine

Decitabine

Decitabine is believed to exert its antineoplastic effects after phosphorylation and direct incorporation into DNA and inhibition of DNA methyltransferase, causing hypomethylation of DNA and cellular differentiation or apoptosis. Decitabine inhibits DNA methylation in vitro, which is achieved at concentrations that do not cause major suppression of DNA synthesis. Decitabine-induced hypomethylation in neoplastic cells may restore normal function to genes that are critical for the control of cellular differentiation and proliferation. In rapidly dividing cells, the cytotoxicity of decitabine may also be attributed to the formation of covalent adducts between DNA methyltransferase and decitabine incorporated into DNA. Non-proliferating cells are relatively insensitive to decitabine.

Indications

All FDA-approved indications.

Dosage

FDA-approved dosages.

TAR Requirement

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Billing

HCPCS codes:

J0894 (injection, decitabine, 1 mg).

J0893 (injection, decitabine (sun pharma) not therapeutically equivalent to J0894, 1 mg).

Degarelix

Degarelix is reimbursable for treatment of advanced prostate cancer in males.

Dosage

Maximum dosage is 240 mg (quantity equals 240); frequency is limited to once every rolling 28 days.

Required Codes

Degarelix is reimbursable when billed in conjunction with ICD-10-CM diagnosis code C61.

Billing

HCPCS code J9155 (injection, degarelix, 1 mg).

One unit equals 1 mg.

Denileukin Diftitox

Denileukin diftitox is reimbursable for patients with persistent cutaneous T-cell lymphoma.

Authorization

A TAR must be submitted with the following documentation that the patient has:

- A diagnosis of recurrent or persistent cutaneous T-cell lymphoma; and
- Stage IB, IIA, IIB, IIIA, IIIB or IVA (denileukin diftitox is not covered for patients in stage IA or IVB); and
- Failed or been intolerant of other U.S. Food and Drug Administration approved medications such as topical chemotherapeutic agents, and/or electron beam therapy, and/or phototherapy, and/or interferon, and/or topical retinoids, and/or systemic retinoids, and/or extracorporeal photopheresis, and/or single agent chemotherapy, and/or combination chemotherapy; and
- At least 20 percent of the malignant cells in any tissue sample expressing the CD25 component of the Interleukin-2 receptor

The initial TAR is valid only for three cycles. Subsequent authorization should be based upon patient response and the documentation submitted with the TAR.

Dosage

The usual dosage is 9 or 18 mcg/kg/day, administered intravenously for five consecutive days, every 21 days. Optimal duration of therapy has not been determined.

Billing

HCPCS code J9160 (injection, denileukin diftitox, 300 mcg).

Denosumab

Policy for the use of denosumab in the treatment of giant cell tumor of bone may be found in *Injections: Drugs A-D Policy* section in this manual.

Docetaxel

Docetaxel is an antineoplastic agent that acts by disrupting the microtubular network in cells that is essential for mitotic and interphase cellular functions. Docetaxel binds to free tubulin and promotes the assembly of tubulin into stable microtubules while simultaneously inhibiting their disassembly. This leads to the production of microtubule bundles without normal function and to the stabilization of microtubules, which results in the inhibition of mitosis in cells.

Indications

Docetaxel is indicated for the treatment of:

- Breast cancer
- Esophageal cancer
- Gastric cancer
- Head and neck cancer
- Non-small cell lung cancer
- Occult primary
- Ovarian cancer
- Prostate cancer
- Small cell lung cancer

Billing

HCPCS code J9171 (injection, docetaxel, 1 mg).

One (1) unit equals 1 mg.

CPT code 96413 (chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug) may be billed in conjunction with docetaxel and is separately reimbursable.

When billing for a quantity greater than 200 mg (200 units), providers must document that the patient's body surface area exceeds 2 m².

Dostarlimab-gxly (Jemperli)

Jemperli is a programmed death receptor-1 (PD-1)-blocking antibody. It is an anti-PD-1 humanized IgG4 monoclonal antibody, which inhibits programmed cell death-1 (PD-1) activity by binding to the PD-1 receptor on T-cells to block PD-1 ligands (PD-L1 and PD-L2) from binding. Blocking the PD-1 pathway inhibits the negative immune regulation caused by PD-1 receptor signaling (Hamid 2013).

Indications

All FDA-approved indications

Age Limits

Must be 18-years of age or older

Dosage

FDA-approved dosages

TAR Requirement

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Billing

HCPCS code J9272 (injection, dostarlimab-gxly, 10 mg)

Prescribing Restrictions

Frequency of billing equals 500 mg/50 units every three weeks for four doses, then three weeks after dose four, continue with 1,000 mg/100 units every six weeks.

Maximum billing unit(s) equals 1,000 mg/100 units

Doxorubicin HCl

Doxorubicin is an anthracycline topoisomerase inhibitor isolated from *Streptomyces peucetius* var. *caesius*.

The mechanism of action of doxorubicin HCl is thought to be related to its ability to bind DNA and inhibit nucleic acid synthesis. Cell structure studies have demonstrated rapid cell penetration and perinuclear chromatin binding, rapid inhibition of mitotic activity and nucleic acid synthesis, and induction of mutagenesis and chromosomal aberrations.

Indications

Doxorubicin is indicated for the treatment of:

- Acute lymphoblastic leukemia
- Acute myeloblastic leukemia
- Wilms' tumor
- Soft tissue and bone sarcomas
- Ovarian carcinoma
- Transitional cell bladder carcinoma
- Thyroid carcinoma
- Gastric carcinoma
- Hodgkin lymphoma
- Non-Hodgkin lymphoma
- Small cell lung cancer
- Breast cancer

Dosage

The dose is variable depending upon the malignancy being treated. The maximum dose allowed is 200 mg, unless there is documentation that the patient's body surface is greater than 2.75 m².

Billing

HCPCS code J9000 (injection, doxorubicin hydrochloride, 10 mg).

Doxorubicin HCl Liposome

Doxorubicin is an anthracycline topoisomerase inhibitor isolated from *Streptomyces peucetius* var. *caesius*. Doxorubicin HCl liposome is doxorubicin hydrochloride encapsulated in liposomes for intravenous administration.

The mechanism of action of doxorubicin HCl is thought to be related to its ability to bind DNA and inhibit nucleic acid synthesis. Cell structure studies have demonstrated rapid cell penetration and perinuclear chromatin binding, rapid inhibition of mitotic activity and nucleic acid synthesis, and induction of mutagenesis and chromosomal aberrations.

The liposomes in doxorubicin HCl liposome are microscopic vesicles composed of a phospholipid bilayer that are capable of encapsulating active drugs. The liposomes are formulated with surface-bound methoxypolyethylene glycol, a process often referred to as pegylation, to protect liposomes from detection by the mononuclear phagocyte system and to increase blood circulation time.

Indications

Doxorubicin HCl liposome is indicated for the treatment of:

- Ovarian cancer after failure of platinum-based chemotherapy
- AIDS-related Kaposi's Sarcoma after failure of prior systemic chemotherapy or intolerance to such therapy
- Multiple myeloma in combination with bortezomib in patients who have not previously received bortezomib and have received at least one prior therapy
- Breast cancer

Dosage

The dosage is variable depending upon the malignancy being treated. Doses greater than 140 mg require documentation that the patient's body surface area (BSA) is greater than 2.5 m².

Required Codes

Doxorubicin HCl liposome is reimbursable when billed with any of the following ICD-10-CM diagnosis codes:

C46.0 thru C46.9

C88.2 thru C90.32

C50.011 thru C50.929

D47.Z9

C56.1 thru C57.4

Billing

HCPCS code Q2049 (injection doxorubicin hydrochloride, liposomal, imported Lipodox[®], 10 mg)

HCPCS code Q2050 (injection, doxorubicin hydrochloride, liposomal, not otherwise specified, 10 mg)

CPT code 96413 (chemotherapy administration intravenous infusion technique; up to one hour, single or initial substance/drug) is reimbursable when billed with HCPCS code Q2049 or Q2050.

Durvalumab (Imfinzi)

Durvalumab is a human immunoglobulin G1 kappa monoclonal antibody which blocks programmed cell death ligand 1 (PD-L1) binding to programmed death-1 (PD-1) and cluster of differentiation 80 (CD80) (B7.1); PD-L1 blockade leads to increased T-cell activation, allowing T-cells to kill tumor cells. PD-L1 is an immune check point protein expressed on tumor cells and tumor infiltrating cells and down regulates anti-tumor T-cell function by binding to PD-1 and B7.1; blocking PD-1 and B7.1 interactions restores antitumor T-cell function.

Indications

All FDA-approved indications.

Dosage

All FDA-approved dosages.

TAR Requirement

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Age

Must be 18 years of age or older.

Billing

HCPCS code J9173 (injection, durvalumab, 10 mg).

One (1) unit of J9173 equals 10 mg of durvalumab.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.