Clinical Policy: Tisagenlecleucel (Kymriah)

Reference Number: CP.PHAR.361
Effective Date: 12.01.17
Last Review Date: 02.26
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Tisagenlecleucel (Kymriah™) is a CD19-directed, genetically modified, autologous T-cell immunotherapy.

FDA Approved Indication(s)

Kymriah is indicated for the treatment of:

- Patients up to 25 years of age with B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse
- Adult patients with relapsed or refractory large B-cell lymphoma (LBCL) after two or more lines of systemic therapy including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, high grade B-cell lymphoma and DLBCL arising from follicular lymphoma
- Adult patients with relapsed or refractory follicular lymphoma (FL) after two or more lines of systemic therapy^

Limitation(s) of use: Kymriah is not indicated for treatment of patients with primary central nervous system (CNS) lymphoma.*

** Efficacy of Kymriah for the treatment of LBCL has not been established in patients with active CNS disease (see Appendix D).*
^ This indication is approved under accelerated approval based on response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results, or other clinical information) supporting that member has met all approval criteria.

All requests reviewed under this policy **require Precision Drug Action Committee (PDAC) Utilization Management Review**. Refer to CC.PHAR.21 for process details.

It is the policy of health plans affiliated with Centene Corporation® that Kymriah is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Acute Lymphoblastic Leukemia* (must meet all)**:**

**Only for initial treatment dose; subsequent doses will not be covered.*

1. Diagnosis of B-cell precursor ALL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≤ 25 years;

4. Documentation of CD19 tumor expression;
5. Recent (within the last 30 days) documentation of one of the following (a or b):
   a. Absolute lymphocyte count (ALC) ≥ 500/µL;
   b. CD3 (T-cells) cell count of ≥ 150/µL if ALC < 500/µL;
6. Request meets one of the following (a, b, c, or d):
   a. Disease is refractory, defined as failure to achieve a complete response following induction therapy with ≥ 2 cycles of standard chemotherapy regimen (primary refractory) or after 1 cycle of standard chemotherapy for relapsed leukemia (chemorefractory);
   b. Member has had ≥ 2 relapses;
   c. Disease is relapsed or refractory, Philadelphia chromosome positive (Ph+): member has received 2 lines of chemotherapy that included 2 tyrosine kinase inhibitors (e.g., imatinib, Sprycel®, Tasigna®, Bosulif®, Iclusig®);
      **Prior authorization may be required for tyrosine kinase inhibitors*
   d. Member has relapsed following allogeneic stem cell transplantation (SCT) and must be ≥ 6 months from SCT at the time of Kymriah infusion;
7. Member has not previously received treatment with CAR T-cell immunotherapy (e.g., Abecma®, Carvykti™, Breyanzi™, Tecartus®, Yescarta™);
8. Kymriah is not prescribed concurrently with other CAR T-cell immunotherapy (e.g., Abecma, Carvykti, Breyanzi, Tecartus, Yescarta);
9. Dose does not exceed (a or b):
   a. Weight ≤ 50 kg: 5.0×10^6 chimeric antigen receptor (CAR)-positive viable T cells per kg of body weight;
   b. Weight > 50 kg: 2.5×10^8 CAR-positive viable T cells.

Approval duration: 3 months ***(1 dose only, with 4 doses of tocilizumab (Actemra) if requested at up to 800 mg per dose)***

B. Large B-Cell Lymphoma* (must meet all)**:**
**Only for initial treatment dose; subsequent doses will not be covered.*

1. Diagnosis of one of the following LBCL (a–h);
   a. DLBCL;
   b. Primary mediastinal large b cell lymphoma (PMBCL);
   c. Transformed follicular lymphoma (TFL) to DLBCL;
   d. Transformed nodal marginal zone lymphoma (MZL) to DLBCL;
   e. High-grade B-cell lymphomas with MYC and BCL2 rearrangements or high-grade B-cell lymphomas, not otherwise specified;
   f. Monomorphic post-transplant lymphoproliferative disorders (B-cell type);
   g. HIV-related DLBCL, primary effusion lymphoma, HHV8-positive DLBCL, and HIV-related plasmablastic lymphoma;
   h. Richter transformation (off-label);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Recent (within the last 30 days) ALC ≥ 300/µL;
5. Request is for one of the following (a, b, or c):
   a. Disease is refractory or member has relapsed after ≥ 2 lines of systemic therapy that includes rituximab* and one anthracycline-containing regimen (e.g., doxorubicin);

**Prior authorization may be required for rituximab*

b. Disease relapsed more than 12 months after completion of first-line therapy and partial response following second-line therapy (off-label);
c. Richter transformation after ≥ 1 prior systemic therapy regimen (e.g., BCL2 inhibitor, anti-CD20 monoclonal antibody (e.g., rituximab*), BTK inhibitor) (off-label);

6. Member does not have active or primary CNS disease (*see Appendix D*);
7. Member has not previously received treatment with CAR T-cell immunotherapy (e.g., Abecma, Carvykti, Breyanzi, Tecartus, Yescarta);
8. Kymriah is not prescribed concurrently with other CAR T-cell immunotherapy (e.g., Abecma, Carvykti, Breyanzi, Tecartus, Yescarta);
9. Dose does not exceed 6.0 x 10^8 CAR-positive viable T cells.

Approval duration: 3 months *(1 dose only, with 4 doses of tocilizumab (Actemra) if requested at up to 800 mg per dose)*

C. Follicular Lymphoma* (must meet all)**:**

**Only for initial treatment dose; subsequent doses will not be covered.*

1. Diagnosis of FL grade 1, 2, or 3a;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Request meets one of the following (a or b):
   a. Disease is relapsed/refractory after ≥ 2 lines of systemic therapy that includes a combination of an anti-CD20 monoclonal antibody (e.g., rituximab or Gazyva®) and an alkylating agent (e.g., bendamustine, cyclophosphamide, chlorambucil)*;
   **Prior authorization may be required*
   b. Member has relapsed following autologous SCT;
5. Member does not have active CNS involvement by malignancy;
6. Member has not previously received treatment with CAR T-cell immunotherapy (e.g., Abecma, Carvykti, Breyanzi, Tecartus, Yescarta);
7. Kymriah is not prescribed concurrently with other CAR T-cell immunotherapy (e.g., Abecma, Carvykti, Breyanzi, Tecartus, Yescarta);
8. Dose does not exceed a single administration of 6 x 10^8 CAR-positive viable T cells.

Approval duration: 3 months *(1 dose only, with 4 doses of tocilizumab (Actemra) if requested at up to 800 mg per dose)*

D. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I

1. Continued therapy will not be authorized as Kymriah is indicated to be dosed one time only.

Approval duration: Not applicable

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents;

B. LBCL: Active or primary CNS disease (*see Appendix D*).

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALC: absolute lymphocyte count
ALL: acute lymphoblastic leukemia
CAR: chimeric antigen receptor
CML: chronic myelogenous leukemia
CNS: central nervous system
CRS: cytokine release syndrome
CSF: cerebral spinal fluid
DLBCL: diffuse large B-cell lymphoma
FDA: Food and Drug Administration
FL: follicular lymphoma
LBCL: large B-cell lymphoma
MZL: marginal zone lymphoma
Ph+: Philadelphia chromosome positive

PMBCL: primary mediastinal large B-cell lymphoma
r/r: relapsed or refractory
REMS: risk evaluation and mitigation strategy
SCT: stem cell transplantation
TFL: transformed follicular lymphoma
WBC: white blood cell

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Acute Lymphoblastic Leukemia		
imatinib mesylate (Gleevec®)	Adults with Ph+ ALL: 600 mg/day Pediatrics with Ph+ ALL: 340 mg/m^2/day	Adults: 800 mg/day Pediatrics: 600 mg/day
Sprycel® (dasatinib)	Ph+ ALL: 140 mg per day	180 mg/day
Iclusig® (ponatinib)	Ph+ ALL: 45 mg per day	45 mg/day
Tasigna® (nilotinib)	Resistant or intolerant Ph+ CML-CP and CML-AP: 400 mg twice per day	800 mg/day
Bosulif® (bosutinib)	Ph+ CML: 500 mg per day	600 mg/day
Various combination regimens that may include the following: daunorubicin, doxorubicin, vincristine, dexamethasone, prednisone, pegaspargase, nelarabine, methotrexate, cyclophosphamide, cytarabine, rituximab, 6-mercaptopurine	Ph- ALL: varies	Varies
Large B-Cell Lymphoma		
First-Line Treatment Regimens		
RCHOP (Rituxan® (rituximab), cyclophosphamide, doxorubicin, vincristine, prednisone)	Varies	Varies
RCEPP (Rituxan® (rituximab), cyclophosphamide, etoposide, prednisone, procarbazine)	Varies	Varies
RCDOP (Rituxan® (rituximab), cyclophosphamide, liposomal doxorubicin, vincristine, prednisone)	Varies	Varies
DA-EPOCH (etoposide, prednisone, vincristine,	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
cyclophosphamide, doxorubicin) + Rituxan® (rituximab)		
RCEOP (Rituxan (rituximab), cyclophosphamide, etoposide, vincristine, prednisone)	Varies	Varies
RGCVP (Rituxan® (rituximab), gemcitabine, cyclophosphamide, vincristine, prednisone)	Varies	Varies
Pola-R-CHP (polatuzumab vedotin-piiq, rituximab, cyclophosphamide, doxorubicin, prednisone)	Varies	Varies
Second-Line Treatment Regimens		
Bendeka® (bendamustine) ± Rituxan® (rituximab)	Varies	Varies
CEPP (cyclophosphamide, etoposide, prednisone, procarbazine) ± Rituxan® (rituximab)	Varies	Varies
CEOP (cyclophosphamide, etoposide, vincristine, prednisone) ± Rituxan® (rituximab)	Varies	Varies
DA-EPOCH ± Rituxan® (rituximab)	Varies	Varies
GDP (gemcitabine, dexamethasone, cisplatin) ± Rituxan® (rituximab)	Varies	Varies
gemcitabine, dexamethasone, carboplatin ± Rituxan® (rituximab)	Varies	Varies
GemOx (gemcitabine, oxaliplatin) ± Rituxan® (rituximab)	Varies	Varies
gemcitabine, vinorelbine ± Rituxan® (rituximab)	Varies	Varies
lenalidomide ± Rituxan® (rituximab)	Varies	Varies
Rituxan (rituximab)	Varies	Varies
DHA (dexamethasone, cytarabine) + platinum (carboplatin, cisplatin, or oxaliplatin) ± Rituxan® (rituximab)	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
ESHAP (etoposide, methylprednisolone, cytarabine, cisplatin) ± Rituxan® (rituximab)	Varies	Varies
ICE (ifosfamide, carboplatin, etoposide) ± Rituxan® (rituximab)	Varies	Varies
MINE (mesna, ifosfamide, mitoxantrone, etoposide) ± Rituxan® (rituximab)	Varies	Varies
FL First-Line and Second-Line + Subsequent Treatment Regimens		
bendamustine + (Gazyva® (obinutuzumab) or rituximab)	Varies	Varies
CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) + (Gazyva® (obinutuzumab) or rituximab)	Varies	Varies
CHOP + Gazyva® (obinutuzumab) or rituximab	Varies	Varies
CVP (cyclophosphamide, vincristine, prednisone) + Gazyva® (obinutuzumab) or rituximab		
rituximab ± (lenalidomide, chlorambucil, or cyclophosphamide)	Varies	Varies
rituximab	Varies	Varies
Gazyva® (obinutuzumab)	Varies	Varies
lenalidomide + Gazyva® (obinutuzumab)	Varies	Varies
Zevalin® (ibritumomab tiuxetan)	Varies	Varies
Tazverik™ (tazemetostat)	800 mg PO BID	1,600 mg/day
Richter Transformation Prior Treatment Regimens		
Venclexta® (venetoclax)/Acalabrutinib ± Gazyva® (obinutuzumab)	Varies	Varies
Venclexta® (venetoclax) + Gazyva® (obinutuzumab)	Varies	Varies
Calquence® (acalabrutinib) ± Gazyva® (obinutuzumab)	Varies	Varies
Brukinsa® (zanubrutinib)	160 mg PO BID or 320 mg PO QD	320 mg/day 640 mg/day when used with a moderate CYP3A4 inducer

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Venclexta® (venetoclax) ± rituximab	Varies	Varies
Imbruvica® (ibrutinib)	420 mg PO QD	420 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s):
  - Cytokine Release Syndrome (CRS), including fatal or life-threatening reactions, occurred in patients receiving Kymriah. Do not administer Kymriah to patients with active infection or inflammatory disorders. Treat severe or life-threatening CRS with tocilizumab or tocilizumab and corticosteroids.
  - Neurological toxicities, which may be severe or life-threatening, can occur following treatment with Kymriah, including concurrently with CRS. Monitor for neurological events after treatment with Kymriah. Provide supportive care as needed.
  - T cell malignancies have occurred following treatment of hematologic malignancies with BCMA- and CD19- directed genetically modified autologous T cell immunotherapies, including Kymriah.

Appendix D: General Information

- Refractory ALL is defined as complete remission not achieved after 2 cycles of standard chemotherapy or 1 cycle of standard chemotherapy due to relapsed leukemia.[2]
- Novartis, the manufacturer of Kymriah, recommends that patients with ALL have an ALC ≥ 500/µL for leukapheresis collection. Patients with an ALC < 500/µL during leukapheresis screening should have had a CD3 (T-cells) cell count of ≥ 150/µL to be eligible for leukapheresis collection.
- The JULIET trial in patients with DLBCL excluded patients with an ALC <300/µL.
- Patients with active CNS disease were excluded in the ELIANA trial for ALL and the JULIET trial for DLBCL. In the ALL trial, active CNS involvement by malignancy was defined by CNS-3 per NCCN guidelines (WBC ≥ 5/mcL in CSF with presence of lymphoblasts). In the DLBCL trial, active CNS involvement was assessed during screening by CNS symptom assessment to evaluate clinical evidence of CNS disease, CNS brain imaging (MRI/CT) if clinically indicated, and CSF cytology only if there was suspicion of CNS involvement.
- NCCN treatment guidelines for ALL state that CNS-directed therapy may include cranial irradiation, intrathecal chemotherapy (e.g., methotrexate, cytarabine, corticosteroids), and/or systemic chemotherapy (e.g., high-dose methotrexate, intermediate or high-dose cytarabine, pegaspargase). For primary DLBCL of the CNS (i.e., primary CNS lymphoma), NCCN treatment guidelines for CNS cancers recommend a high-dose methotrexate induction based regimen or other systemic therapy regimen if patient is unsuitable for or intolerant to high-dose methotrexate. If a complete response is achieved, or complete response unconfirmed, continue with consolidation therapy with high-dose systemic therapy with stem cell rescue, high-dose cytarabine with or without etoposide, low dose whole brain radiation therapy, temozolomide (after whole brain radiation

therapy), or continuation with monthly high-dose methotrexate/rituximab-based regimen. Alternatively, whole brain radiation therapy is recommended if patient is not a candidate for systemic therapy.

- NCCN Pediatric ALL treatment guidelines state that Kymriah can be used in relapsed disease that includes medullary and/or extramedullary disease as CAR-T cells have shown activity against extramedullary disease. NCCN defines extramedullary as disease involving the CNS or testes.
- Frigault et al. 2019 reported on their institutional experience with 8 secondary CNS lymphoma patients treated with Kymriah. The best response assessed 28 days post-Kymriah infusion in these patients included complete responses (n = 2) and partial response (n = 2). Additionally, two patients died within 30 days of Kymriah infusion, the remaining two patients experienced disease progression. All patients were receiving CNS-directed therapy for refractory disease up until lymphodepletion.
- Enrollment in the JULIET trial in patients with DLBCL did not require CD19 positive tumor expression. In a subgroup analysis the best overall response rate was comparable between patients with unequivocal CD19 expression (49%, 95% CI 34 to 64, n = 49) and patients with low or negative CD19 expression (50%, 95% CI 29 to 71, n = 24).

V. Dosage and Administration

Indication	Dosing Regimen*	Maximum Dose
ALL	≤ 50 kg: 0.2 to 5.0 x 10^6 CAR-positive viable T cells per kg of body weight IV > 50 kg: 0.1 to 2.5 x 10^8 CAR-positive viable T cells IV	≤ 50 kg: 5.0 x 10^6 CAR-positive viable T cells per kg of body weight > 50 kg: 2.5 x 10^8 CAR-positive viable T cells
LBCL	0.6 to 6.0 x 10^8 CAR-positive viable T cells IV	6.0 x 10^8 CAR-positive viable T-cells
FL	0.6 to 6.0 x 10^8 CAR-positive viable T cells IV	6.0 x 10^8 CAR-positive viable T-cells

*****_Kymriah should be administered at a certified healthcare facility_

VI. Product Availability

Single-dose unit infusion bag: frozen suspension of genetically modified autologous T-cells labeled for the specific recipient

VII. References

1. Kymriah Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; June 2025. Available at: https://www.us.kymriah.com/. Accessed October 13, 2025.
2. Data on File. Novartis Pharmaceuticals Corporation; East Hanover, NJ. November 2020.
3. National Comprehensive Cancer Network. Acute Lymphoblastic Leukemia Version 2.2025. Available at https://www.nccn.org/professionals/physician_gls/pdf/all.pdf. Accessed November 6, 2025.
4. National Comprehensive Cancer Network. Pediatric Acute Lymphoblastic Leukemia Version 1.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ped_all.pdf. Accessed November 6, 2025.

5. National Comprehensive Cancer Network Drug and Biologics Compendium. Available at http://www.nccn.org/professionals/drug_compendium. Accessed November 6, 2025.
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8. Schuster SJ, Bishop MR, Tam CS, et al. Tisagenlecleucel in adult relapsed or refractor diffuse large B-cell lymphoma. N Engl J Med 2019; 380(1): 45-56.
9. Frigault MJ, Dietrich J, Martinez-Lage M, et al. Tisagenlecleucel CAR T-cell therapy in secondary CNS lymphoma. Blood. 2019; 134(11): 860-866.
10. Schuster SJ, Dickinson MJ, Dreyling M, et al. Efficacy and safety of tisagenlecleucel (tisa-cel) in adult patients (Pts) with relapsed/refractory follicular lymphoma (r/r FL): Primary analysis of the phase 2 Elara trial. Oral abstract #7508. 2021 American Society of Clinical Oncology (ASCO) Annual Meeting; Jun 7, 2021; Virtual.
11. Maude SL, Laetsch TW, Buechner J, et al. Tisagenlecleucel in Children and Young Adults with B-Cell Lymphoblastic Leukemia. N Engl J Med. 2018 Feb 1;378(5):439-448.
12. Fowler NH, Dickinson M, Dreyling M, et al. Tisagenlecleucel in adult relapsed or refractory follicular lymphoma: the phase 2 ELARA trial. Nature Medicine 2022; 28(2), 325-332.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 annual review: to align with other CAR-T policies, added requirement that member has not previously received CAR-T therapy and Kymriah is not prescribed concurrently with other CAR-T therapy; for ALL clarified that hematopoietic stem cell transplantation should more specifically refer to allogeneic stem cell transplantation; added preemptive criteria for the pending FDA approval of FL indication; references reviewed and updated.	11.15.21	02.22
Added additional information to Appendix D related to clinical trial definitions of active CNS disease.	03.28.22	
RT2: pre-emptive criteria converted for new FDA approved indication: r/r FL after 2 or more lines of systemic therapy; references reviewed and updated.	06.28.22	08.22

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Template changes applied to other diagnoses/indications.	09.22.22	
1Q 2023 annual review: for LBCL added NCCN supported use in AIDS-related DLBCL, primary effusion lymphoma, and HHV8-positive DLBCL; references reviewed and updated.	09.20.22	02.23
1Q 2024 annual review: per NCCN for Ph+ ALL, revised requirement to include relapse or refractory disease and modified verbiage from "failure of" to "member has received 2 lines of chemotherapy that included 2 tyrosine kinase inhibitors," revised reference from AIDS to HIV consistent with NCCN; added Carvykti as an additional example of CAR T-cell immunotherapy that Kymriah should not be prescribed concurrently with or that member has previously received; references reviewed and updated.	10.04.23	02.24
1Q 2025 annual review: per NCCN Compendium for LBCL added off-label use for disease relapsed more than 12 months after completion of first-line therapy and partial response following second-line therapy; added the following to Appendix C per updated prescribing information: T cell malignancies have occurred following treatment of hematologic malignancies with BCMA- and CD19-directed genetically modified autologous T cell immunotherapies, including Kymriah. Kymriah is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Kymriah REMS; references reviewed and updated.	10.17.24	02.25
Updated language under Policy/Criteria to effectively redirect prior authorization reviews to Precision Drug Action Committee (PDAC) Utilization Management Review.	11.03.25	
1Q 2026 annual review: added NCCN Compendium supported off-label use in LBCL for Richter transformation and HIV-related plasmablastic lymphoma; references reviewed and updated.	11.06.25	02.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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