Clinical Policy: Blinatumomab (Blincyto)

Reference Number: LA.PHAR.312
Effective Date:
Last Review Date: 06.15.23
Line of Business: Medicaid

Coding Implications
Revision Log

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

Please note: This policy is for medical benefit

Description
Blinatumomab (Blincyto®) is a bispecific CD19-directed CD3 T-cell engager.

FDA Approved Indication(s)
Blincyto is indicated in adults and pediatric children patients for the treatment of:

- CD19-positive B-cell precursor acute lymphoblastic leukemia (B- cell precursor ALL) in first or second complete remission with minimal residual disease (MRD) ≥ 0.1%.*
- *This indication is approved under accelerated approval based on MRD response rate and hematological relapse-free survival. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.*
- Relapsed or refractory CD19-positive B-cell precursor ALL.

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.

It is the policy of Louisiana Healthcare Connections that Blincyto is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of B-cell precursor ALL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Requested as treatment for (a, or b, or c):
   a. B- cell precursor ALL in remission but MRD-positive;
   b. Relapsed or refractory B-cell precursor ALL (i or ii):
      i. Philadelphia chromosome-negative (Ph-) disease;
      ii. Philadelphia chromosome-positive (Ph+) disease and either (1 or 2):
         1. intolerant or refractory to at least one second- or subsequent-generation tyrosine kinase inhibitor* (TKI; i.e., imatinib, Sprycel®, Tasigna®, Bosulif®, Iclusig®);
         2. Prescribed in combination with a TKI;

   Prior authorization may be required for these agents.
   c. Infant ALL, and prescribed in combination with an Interfant regimen;
      Prior authorization may be required for these agents.
4. Request meets one of the following (a or b):*

a. Dose does not exceed 28 mcg per day;
b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 6 months

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 LA.PMN.255
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: LA.PMN.53 for Medicaid.

II. Continued Therapy

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

1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Blincyto for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 28 mcg per day;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months

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 LA.PMN.255
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: LA.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 policy – LA.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALL: acute lymphoblastic leukemia
B-cell precursor ALL: B-cell precursor acute lymphoblastic leukemia
CR: complete remission
FDA: Food and Drug Administration
MRD: minimal residual disease

NCCN: National Comprehensive Cancer Network

TKI: tyrosine kinase inhibitor

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
Sprycel® (dasatinib)	Ph+ ALL: ~~Labeled use~~ Adults: 140 mg PO QD *(resistance or intolerance to prior therapy)* Children and adolescents: PO QD weight-based *(newly diagnosed disease)*	Adults: 180 mg/day Children: 100 mg/day
Iclusig® (ponatinib)	Ph+ ALL: ~~Labeled use~~ Adults: 45 mg PO QD *(T315I-positive disease or no other TKI is indicated)*	45 mg/day
Tasigna® (nilotinib)	Ph+ ALL: ~~‡Off-label use~~	Varies
Bosulif® (bosutinib)	Ph+ ALL: ~~‡Off-label use~~	Varies
imatinib (Gleevec®)	Ph+ ALL: ~~Labeled use~~ Adults: 600 mg PO once daily until disease progression	600 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.
**The above-referenced TKIs are NCCN recommended for PH+ ALL (category 1 or 2a).*
‡ off-label use

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): known hypersensitivity to blinatumomab or to any component of the product formulation
- Boxed warning(s): cytokine release syndrome (CRS); neurological toxicities

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose

B-cell precursor ALL (in remission and MRD-positive)	Treatment course: 1 cycle of Blincyto IV for induction followed by up to 3 additional cycles for consolidation.
	• Patients ≥ 45 kg receive a fixed dose
	  o Induction cycle 1
	  ▪ Days 1-28: 28 mcg/day
	  ▪ Days 29-42: 14-day treatment-free interval
	  o Consolidation cycles 2-4
	  ▪ Days 1-28: 28 mcg/day
	  ▪ Days 29-42: 14-day treatment-free interval
	• Patients < 45 kg based on body surface area (BSA)
	  o Induction cycle 1
	  ▪ Days 1-28: 15 mcg/m^2/day
		28 mcg/day

Indication	Dosing Regimen	Maximum Dose
	▪ Days 29-42: 14-day treatment-free interval o Consolidation cycles 2-4 ▪ Days 1-28: 15 mcg/m^2/day ▪ Days 29-42: 14-day treatment-free interval	
B- cell precursor ALL (relapsed or refractory)	Treatment course: 2 cycles of Blincyto IV for induction followed by 3 cycles for consolidation and up to 4 cycles of continued therapy. • Patients ≥ 45 kg receive a fixed dose o Induction cycle 1 ▪ Days 1-7: 9 mcg/day ▪ Days 8-28: 28 mcg/day ▪ Days 29-42: 14-day treatment-free interval o Induction cycle 2 ▪ Days 1-28: 28 mcg/day ▪ Days 29-42: 14-day treatment-free interval o Consolidation cycles 3-5 ▪ Days 1-28: 28 mcg/day ▪ Days 29-42: 14-day treatment-free interval o Continued therapy cycles 6-9 ▪ Days 1-28: 28 mcg/day ▪ Days 29-84: 56-day treatment-free interval • Patients < 45 kg based on body surface area (BSA) o Induction cycle 1 ▪ Days 1-7: 5 mcg/m^2/day ▪ Days 8-28: 15 mcg/m^2/day ▪ Days 29-42: 14-day treatment-free interval o Induction cycle 2 ▪ Days 1-28: 15 mcg/m^2/day ▪ Days 29-42: 14-day treatment-free interval o Consolidation cycles 3-5 ▪ Days 1-28: 15 mcg/m^2/day ▪ Days 29-42: 14-day treatment-free interval o Continued therapy cycles 6-9 ▪ Days 1-28: 15 mcg/m^2/day ▪ Days 29-84: 56-day treatment-free interval	28 mcg/day

VI. Product Availability

Single-dose vial for reconstitution: 35 mcg

VII. References

1. Blincyto Prescribing Information. Thousand Oaks, CA: Amgen, Inc.; ~~February 2022~~June 2023. Available at: http://pi.amgen.com/~/media/amgen/repositorysites/pi-amgen-com/blincyto/blincyto_pi_hcp_english.ashx. Accessed ~~May 2, 2022~~June 27, 2023.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at nccn.org. Accessed May ~~2, 2022~~17, 2023.

3. National Comprehensive Cancer Network Guidelines. Acute Lymphoblastic Leukemia Version 1.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/all.pdf. Accessed May ~~2, 2022~~17, 2023.
4. National Comprehensive Cancer Network Guidelines. Pediatric~~s~~ Acute Lymphoblastic Leukemia Version ~~1.2022~~2.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ped_all.pdf. Accessed May ~~2, 2022~~17, 2023.
5. Clinical Pharmacology [database online]. Elsevier, Inc.; 202~~2~~3. Available at: https://www.clinicalkey.com/pharmacology/. Accessed May ~~2, 2022~~17, 2023.

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
J9039	Injection, blinatumomab, 1 microgram

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted corporate to local policy.	06.15.23	

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. LHCC 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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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

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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.

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