Field Name	Field Description
Prior Authorization Group Description	**Blincyto**
Drugs	**Blincyto (blinatumomab)**
Covered Uses	**Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.**
Exclusion Criteria	**N/A**
Required Medical Information	**See "Other Criteria"**
Age Restriction	**N/A**
Prescriber Restrictions	**Prescriber must be an oncologist/hematologist**
Coverage Duration	**The request will be approved for up to a 12 month duration; if all of the above criteria are not met, the request is referred to a Medical Director for medical necessity review.**
Other Criteria **Revision/Review Date 6/2021**	****Drug is being requested through the member's medical benefit**** **Initial Authorization:** • **Patient has a diagnosis of one of the following forms of Acute Lymphoblastic Leukemia (ALL):** a) **Relapsed B-cell precursor ALL** b) **Refractory B-cell precursor ALL** c) **B-cell precursor ALL in first or second complete remission with minimal residual disease (MRD) greater than or equal to 0.1** • **Provider attests to monitor patient for Cytokine Release Syndrome (CRS) and neurological toxicities** **Reauthorization:** • **Patient has a diagnosis of relapsed or refractory B-cell precursor ALL and has not exceeded 9 total cycles of Blincyto therapy** • **Provider attests to treatment response or stabilization of disease** • **Prescriber attests to monitor patient for Cytokine Release Syndrome (CRS) and neurological toxicities** *****For B-cell precursor ALL with MRD, reauthorization is not allowed***** **Medical Director/clinical reviewer must override criteria when,**

	in his/her professional judgement, the requested item is medically necessary.