Molina Clinical Policy
Kymriah™ (tisagenlecleucel): Policy No. 395

Last Approval: 04/09/2025
Next Review Due By: April 2026

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

POLICY DESCRIPTION

To define and describe the accepted indications for Kymriah (tisagenlecleucel) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

INDICATIONS and/or LIMITATIONS OF COVERAGE

A. Continuation requests for a not – approvable medication shall be exempt from this policy provided:

1. The requested medication was used within the last year without a lapse of more than 30 days of having an active authorization **AND**
2. The member has not experienced disease progression on the requested medication **AND**
3. Additional medication(s) are not being added to the continuation request

B. Acute Lymphoblastic Leukemia (ALL)

1. Kymriah (tisagenlecleucel) may be used in members up to 25 years of age with B-cell ALL that is refractory or in second or later relapse

C. B-Cell Lymphomas

1. Kymriah (tisagenlecleucel) may be used for members who are 18 years of age or older with relapsed or refractory large B-cell lymphoma 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

D. Follicular Lymphomas

1. Kymriah (tisagenlecleucel) may be used for adult members with relapsed or refractory follicular lymphoma after two or more lines of systemic therapy

EXCLUSION CRITERIA

A. Kymriah (tisagenlecleucel) is being used after disease progression on or after CAR-T cell therapy directed towards CD19 antigen [Kymriah ((tisagenlecleucel), Breyanzi (lisocabtagene maraleucel), or Yescarta (axicabtagene ciloleucel].

B. CD-19 positivity not confirmed and documented.

C. Active CNS involvement with lymphoma.

D. Dosing exceeds single dose limit of Kymriah (tisagenlecleucel) 6.0 x 10^8 CAR-positive viable T cells (for B-Cell Lymphomas); 2.5 x 10^8 CAR-positive viable T cells (for ALL).

E. Exceeds duration limit as one time administration.

F. Investigational use of Kymriah (tisagenlecleucel) with an off-label indication that is not sufficient in evidence or is not generally accepted by the medical community. Sufficient evidence that is not supported by CMS recognized compendia or acceptable peer reviewed literature is defined as any of the following:

1. Whether the clinical characteristics of the patient and the cancer are adequately represented in the published evidence.
2. Whether the administered chemotherapy/biologic therapy/immune therapy/targeted therapy/other oncologic therapy regimen is adequately represented in the published evidence.
3. Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients. Generally, the definition of Clinically Meaningful outcomes are those recommended by ASCO, e.g., Hazard Ratio of < 0.80 and the recommended survival benefit for OS and PFS should be at least 3 months.
4. Whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover).
5. That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs.
6. That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
7. That abstracts (including meeting abstracts) without the full article from the approved peer- reviewed journals lack supporting clinical evidence for determining accepted uses of drugs.

MEDICATION MANAGEMENT

Please refer to the FDA label/package insert for details regarding these topics.

APPLICABLE CPT / HCPCS PROCEDURE CODES

CPT (Current Procedural Terminology)

Code	Description
38225	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day
38226	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (e.g., cryopreservation, storage)
38227	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration
38228	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous

HCPCS (Healthcare Common Procedure Coding System)

Code	Description
Q2042	Tisagenlecleucel, up to 600 million CAR-positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic dose

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

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CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

04/09/2025	Policy reviewed. Added Follicular Lymphoma to indication list.
04/10/2024	Policy reviewed. Changes to coverage criteria include: removal of relapse after allo HSCT under ALL indication, and specific stipulations for relapse under B-cell lymphoma indication. Removed bone marrow reserve, adequate renal/hepatic/cardiac/pulm function, hx of CNS disorder, hx of autoimmune disease, active infection, and previous allo HSCT from exclusion criteria.
06/14/2023	Policy revision to include members with relapsed/refractory ALL progressed after 2 lines of standard chemotherapy andadded exclusion criteria-must have documented CD19. Removed codes C9399, J3490, J3590, and J9999.
08/10/2022	Adopted NCH policy and retired MCP.

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