# Clinical Policy: Obecabtagene Autoleucel (Aucatzyl)

Reference Number: CP.PHAR.675
Effective Date: 11.08.24
Last Review Date: 02.25
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

Obecabtagene autoleucel (Aucatzyl®) is a CD19-directed chimeric antigen receptor (CAR) T-cell therapy.

## FDA Approved Indication(s)

Aucatzyl is indicated for the treatment of adult patients with relapsed or refractory B-cell acute lymphoblastic leukemia (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.*

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 Aucatzyl 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 ≥ 18 years;
4. Request meets one of the following (a or b):
   a. Member has relapsed or refractory disease defined as one of the following (i - iv):
      i. Primary refractory disease;
      ii. First relapse if first remission ≤ 12 months;
      iii. Relapsed or refractory disease after 2 or more lines of systemic therapy;
      iv. Relapsed or refractory disease following allogeneic stem cell transplantation (allo-SCT) and must be 3 months from allo-SCT at the time of Aucatzyl infusion;
   b. Disease is Philadelphia chromosome positive (Ph+), relapsed or refractory, and one of the following (i, ii, or iii):
      i. Member has failed 2 tyrosine kinase inhibitors (e.g., imatinib, Sprycel®, Tasigna®, Bosulif®, Iclusig®);

ii. Member has failed one second-generation tyrosine kinase inhibitor (e.g., Bosulif, Sprycel, Tasigna);
iii. Member has a contraindication to all tyrosine kinase inhibitors;
**Prior authorization may be required for tyrosine kinase inhibitors*

5. If previously treated with Blincyto®, documentation of CD19 tumor expression on blasts obtained from bone marrow or peripheral blood after completion of the most recent prior line of therapy;
6. Member does not have central nervous system (CNS)-3 disease* or have a history or presence of any CNS disorder (e.g., seizure disorder, cerebrovascular ischemia/hemorrhage, dementia, cerebellar disease, any autoimmune disease with CNS involvement, posterior reversible encephalopathy syndrome, or cerebral edema);
**CNS-3 disease is defined as detectable cerebrospinal blast cells in a sample of CSF with ≥ 5 white blood cells (WBCs) per $mm^3$*
7. If member has CNS-2 disease*, documentation of no clinically evident neurological changes;
**CNS-2 disease is defined as CSF blast cells with < 5 WBCs/$mm^3$*
8. Member has not previously received treatment with CAR T-cell immunotherapy (e.g., Abecma®, Breyanzi™, Carvykti™, Kymriah™, Tecartus®, Yescarta™);
9. Aucatzyl is not prescribed concurrently with other CAR T-cell immunotherapy (e.g., Abecma, Breyanzi, Carvykti, Kymriah, Tecartus, Yescarta);
10. Dose does not exceed a total of 410 x $10^6$ CAR-positive viable T cells administered as a split dose.

**Approval duration: 3 months** ***(2 doses only, with 8 doses of tocilizumab (Actemra) if requested at up to 800 mg per dose)***

**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.

## II. Continued Therapy

### A. Acute Lymphoblastic Leukemia

1. Continued therapy will not be authorized as Aucatzyl is indicated as a single treatment course.

**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.** History or presence of any CNS disorder, such as a seizure disorder, cerebrovascular ischemia/hemorrhage, dementia, cerebellar disease, any autoimmune disease with CNS involvement, posterior reversible encephalopathy syndrome, or cerebral edema;

**C.** Presence of CNS-3 disease defined as detectable cerebrospinal blast cells in a sample of CSF with ≥ 5 WBCs per $mm^3$ with or without neurological changes.

## IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

ALL: acute lymphoblastic leukemia
allo-SCT: allogeneic stem cell transplantation
CAR: chimeric antigen receptor
CNS: central nervous system
CSF: cerebrospinal fluid
FDA: Food and Drug Administration
MRI: magnetic resonance imaging
Ph+: Philadelphia chromosome positive
WBC: white blood cells

*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 |
|---|---|---|
| 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 |

*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): do not administer Aucatzyl to patients with active infection or inflammatory disorders. disorders. Prior to administering Aucatzyl, ensure that healthcare providers have immediate access to medications and resuscitative equipment to manage CRS.
  - Immune effector cell-associated neurotoxicity syndrome (ICANS) including fatal or life-threatening reactions, occurred in patients receiving Aucatzyl, including concurrently with CRS or after CRS resolution. Monitor for neurologic signs and symptoms after treatment with Aucatzyl. Prior to administering Aucatzyl, ensure that healthcare providers have immediate access to medications and resuscitative equipment to manage neurologic toxicities.
  - T cell malignancies have occurred following treatment of hematologic malignancies with BCMA- and CD19-directed genetically modified autologous T cell immunotherapies.

*Appendix D: General Information*

- Refractory disease is defined as an inability to achieve a complete response to therapy.

- The FELIX Phase Ib/II Study in patients with ALL (NCT04404660) excluded patients with:
  - Presence of CNS-3 disease defined as detectable cerebrospinal blast cells in a sample of CSF with ≥ 5 WBCs per $mm^3$ with or without neurological changes;
  - Presence of CNS-2 disease defined as detectable cerebrospinal blast cells in a sample of CSF with < 5 WBCs per $mm^3$ with neurological changes;
  - History or presence of clinically relevant CNS pathology

## V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| ALL | 410 x $10^6$ CAR-positive viable T cells administered as a split dose on Day 1 and Day 10 | 410 x $10^6$ CAR-positive viable T cells |

## VI. Product Availability

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

## VII. References

1. Aucatzyl Prescribing Information. Gaithersburg, MD: Autolus Inc.; November 2024. Available at: www.autolus.com/media/aj4olbsd/aucatzyl-pi-08-nov2024.pdf. Accessed January 6, 2025.
2. Autolus Therapeutics. (2023, December 9). Autolus Therapeutics Presents Clinical Data Updates at the American Society of Hematology (ASH) Annual Meeting 2023 [Press release]. Available at: https://autolus.gcs-web.com/news-releases/news-release-details/autolus-therapeutics-presents-clinical-data-updates-american. Accessed January 3, 2024.
3. Obecabtagene Autoleucel (obe-cel, AUTO1) for Relapsed/Refractory Adult B-cell Acute Lymphoblastic Leukemia (R/R B-ALL): Pooled Analysis of the Ongoing FELIX Phase Ib/II Study. December 9, 2023. Abstract #222 - oral presentation: American Society of Hematology (ASH) Annual Meeting 2023. Available at: https://www.autolus.com/media/4xbmrn5p/cr_roddie-et-al_felix-pooled-analysis_oral-presentation_ash23_final2-1dec23.pdf. Accessed January 3, 2024.
4. A Study of CD19 Targeted CAR T Cell Therapy in Adult Patients With Relapsed or Refractory B Cell Acute Lymphoblastic Leukaemia (ALL). Clinicaltrials.gov ID: NCT04404660. Updated August 28, 2023. Available at: https://clinicaltrials.gov/study/NCT04404660. Accessed January 3, 2024.
5. National Comprehensive Cancer Network. Acute Lymphoblastic Leukemia Version 3.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/all.pdf. Accessed January 6, 2025.
6. Roddie C, Sandhu KS, Tholouli E, et al. Obecabtagene Autoleucel in Adults with B-Cell Acute Lymphoblastic Leukemia. N Engl J Med. 2024 Nov 27; doi:10.1056/NEJMoa2406526

**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 |
|---|---|
| Q2058 | Obecabtagene autoleucel, 10 up to 400 million cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion |

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| Policy created pre-emptively | 01.03.24 | 05.24 |
| RT1: converted PEPP to post-FDA-approved status; added boxed warnings to Appendix C; modified to allow up to 8 doses of tocilizumab to accommodate split dosing; for relapsed or refractory disease following (allo-SCT) added requirement that it must be 3 months from allo-SCT at the time of Aucatzyl infusion; references reviewed and updated. | 01.14.25 | 02.25 |
| HCPCS code added [C9301], removed codes [C9399, J9999]. | 04.02.25 | |
| HCPCS code added [Q2058] replacing code [C9301]. | 06.03.25 | |
| Updated language under Policy/Criteria to effectively redirect prior authorization reviews to Precision Drug Action Committee (PDAC) Utilization Management Review. | 11.04.25 | |

**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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**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.