MEDICAL COVERAGE POLICY	
SERVICE:	**Obecabtagene autoleucel (Aucatzyl®)**
Policy Number:	**315**
Effective Date:	**5/1/2025**
Last Review:	**3/10/2025**
Next Review:	**3/10/2026**

Important note: *Unless otherwise indicated, medical policies will apply to all lines of business. Medical necessity as defined by this policy does not ensure the benefit is covered. This medical policy does not replace existing federal or state rules and regulations for the applicable service or supply. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan documents. See the member plan specific benefit plan document for a complete description of plan benefits, exclusions, limitations, and conditions of coverage. In the event of a discrepancy, the plan document always supersedes the information in this policy.*

SERVICE: Obecabtagene autoleucel (Aucatzyl®)

PRIOR AUTHORIZATION: Required

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for details.

For Medicare plans, please refer to Medicare NCD 110.24 Chimeric Antigen Receptor (CAR) T-cell Therapy

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid Provider Procedures Manual | TMHP (TMPPM). Texas Mandate HB154 is applicable for Medicaid plans.

Baylor Scott & White Health Plan (BSWHP) may consider obecabtagene autoleucel (Aucatzyl®) medically necessary for the treatment of B-cell precursor acute lymphoblastic leukemia (ALL) **when ALL of the following criteria are met:**

1. Member is ≥ 18 years old; **AND**
2. Member has a diagnosis of relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL) supported by documentation from the patient's medical records and one of the following criteria:
   a. Philadelphia chromosome (Ph)-negative B-cell precursor ALL and meets one of the following:
      i. Primary refractory ALL (not achieving complete response after two cycles of induction chemotherapy)
      ii. First relapse following a remission lasting ≤ 12 months
      iii. Relapsed or refractory ALL after two or more lines of systemic therapy
      iv. Relapsed or refractory ALL at least 3 months after allogeneic stem cell transplantation (HSCT)

      OR
   b. Philadelphia chromosome (Ph)-positive B-cell precursor ALL and meets one of the following:
      i. Member has failed two lines of any tyrosine kinase inhibitor (TKI)
      ii. Member has failed one line of second-generation TKI (i.e., bosutinib, dasatinib, nilotinib)
      iii. Member is intolerant to TKI therapy
      iv. Member has a contraindication to TKI therapy
3. Member has documentation of CD-19 tumor expression; **AND**

4. Member diagnosed by a hematologist or oncologist; **AND**
5. Provider attests member will be using obecabtagene autoleucel at an authorized treatment center; **AND**
6. Obecabtagene autoleucel will be used as monotherapy; **AND**
7. Dose and frequency will be consistent with FDA labeling or NCCN guidelines; **AND**
8. Member has or will receive lymphodepleting chemotherapy (e.g., fludarabine and cyclophosphamide) before infusion of obecabtagene autoleucel; **AND**
9. Member is eligible for apheresis; **AND**
10. Member has an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1; **AND**
11. If the member has received prior treatment with blinatumomab the member's repeat biopsy indicates CD-19 positive disease; **AND**
12. Member does NOT have any of the following:
    a. Received prior treatment with tafasitamab or loncastuximab
    b. Burkitt's Leukemia/Lymphoma
    c. Chronic Myelogenous Leukemia in lymphoid blast crisis
    d. History or presence of clinically relevant central nervous system pathology (ex., epilepsy, paresis, aphasia, stroke, severe brain injuries, dementia, Parkinson's syndrome, uncontrolled mental illness, or psychosis)
    e. Presence of CNS-3 disease or CNS-2 disease with neurologic changes
    f. Presence of active or uncontrolled fungal, bacterial, viral, or other infection requiring systemic antimicrobials for management
    g. Active or latent Hepatitis B virus, active hepatitis C virus, HIV, human T-cell lymphotropic virus (HTLV)-1, HTLV-2, or syphilis positive test
    h. Active significant acute graft versus host disease (overall Grade 2, Seattle criteria)
    i. Moderate/severe chronic graft versus host disease requiring systemic steroids/immunosuppressants (National Institutes of Health consensus criteria)
    j. Experienced grade 3 or higher neurotoxicity following blinatumomab
    k. Received allogeneic stem cell transplantation (HSCT) within three months of planned obecabtagene autoleucel
    l. Pregnancy
13. Member is NOT taking the following medications:
    a. Corticosteroids (greater than 10 mg daily of prednisone or its equivalent) within 7 days of leukapheresis or 72 hours prior to obecabtagene autoleucel
    b. Immunosuppressive (ex., adalimumab, infliximab, tacrolimus, cyclosporine, mycophenolate mofetil) medications within 2 weeks prior to leukapheresis or obecabtagene autoleucel
    c. Donor lymphocyte infusion (DLI) within 2 weeks prior to leukapheresis
    d. Any drug used for graft versus host disease within 2 weeks prior to leukapheresis
    e. Antineoplastic chemotherapy to treat cancer within 1 week prior to leukapheresis or pre-conditioning chemotherapy
    f. Tyrosine Kinase Inhibitors (e.g., bosutinib, dasatinib, imatinib, nilotinib, ponatinib) within 72 hours prior to pre-conditioning chemotherapy

g. Alemtuzumab within 6 months prior to leukapheresis
h. Clofarabine or Cladribine within 3 months prior to leukapheresis
i. Live vaccine ≤4 weeks prior to leukapheresis
j. Intrathecal antineoplastic chemotherapy (ex., methotrexate) within 2 weeks prior to starting pre-conditioning chemotherapy

Obecabtagene autoleucel (Aucatzyl) CAR-T therapy dosing is split into two parts.

BSWHP considers one course of Split dosed therapy as medically necessary per lifetime and considers repeat courses to be experimental and investigational because the effectiveness of this strategy has not been established.

BSWHP considers obecabtagene autoleucel (Aucatzyl) for the treatment of all other indications to be experimental and investigational because the effectiveness of this strategy has not been established.

All requests will be reviewed by both a clinical pharmacist and a medical director.

BACKGROUND:

Chimeric antigen receptor (CAR) T cells and genetically engineered T-cell receptor (TCR T) cells are manufactured by collecting lymphocytes from a patient or donor and modifying them using gene transfer techniques. Viral vectors are introduced that express cell receptors that are highly specific for tumor antigens. CAR T and TCR T cells are then infused back into the patient where they direct a targeted immune response to cancerous tissue. CAR T cells express a hybrid receptor with an extracellular single-chain antibody fragment, a transmembrane domain, and at least 1 intracellular signaling domain. CAR T cells are most often used to treat hematological malignancies, and a common target is B-cell cluster of differentiation antigen 19 (CD19).

The U. S. Food and Drug Administration (FDA) approved obecabtagene autoleucel (Aucatzyl®) on November 8, 2024 for the treatment of adult patients with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL). The review used the Assessment Aid, a voluntary submission from the applicant to facilitate the FDA's assessment. The application was granted regenerative medicine advanced therapy designation and orphan drug designation.

Efficacy was evaluated in FELIX (NCT04404660), an open-label, multicenter, single-arm trial that enrolled adults with relapsed or refractory CD19-positive B-cell ALL. Enrolled patients were required to have relapsed following a remission lasting 12 months or less, relapsed or refractory ALL following two or more prior lines of systemic therapy, or disease that was relapsed or refractory 3 or more months after allogeneic stem cell transplantation.

The major efficacy outcome measures were rate and duration of complete remission (CR) achieved within 3 months after infusion. Additional outcome measures were rate and duration of overall complete remission which includes complete remission and complete remission with incomplete hematologic

recovery (CRi), at any time. Of the 65 patients evaluable for efficacy, 27 patients (42%; 95% confidence interval [CI]: 29%, 54%) achieved CR within 3 months. The median duration of CR achieved within 3 months was 14.1 months (95% CI: 6.1, not reached).

The prescribing information has a boxed warning for cytokine release syndrome (CRS), immune effector cell-associated neurotoxicity syndrome (ICANS) and T cell malignancies. CRS occurred in 75% (Grade 3, 3%) and neurologic toxicities occurred in 64% (Grade ≥3, 12%), including ICANS in 24% (Grade ≥3, 7%).The most common non-laboratory adverse reactions (incidence ≥ 20%) included CRS, infections-pathogen unspecified, musculoskeletal pain, viral infections, fever, nausea, bacterial infectious disorders, diarrhea, febrile neutropenia, ICANS, hypotension, pain, fatigue, headache, encephalopathy, and hemorrhage.

The total recommended dose of obecabtagene autoleucel is 410 X 106 CD19 chimeric antigen receptor (CAR)-positive viable T cells to be administered as split dose infusion on Day 1 and Day 10 (±2 days) based on bone marrow blast assessment and preceded by fludarabine and cyclophosphamide lymphodepleting chemotherapy.

CODES:

Important note: *Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.*

CPT Codes:	38228 Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous
HCPCS Codes:	C9339 Unclassified drugs or biologicals (hospital outpatient use) J9999 Not otherwise classified, antineoplastic drugs
ICD10 codes:	C91.00 Acute lymphoblastic leukemia not having achieved remission C91.02 Acute lymphoblastic leukemia, in relapse
ICD10 Not covered:	

POLICY HISTORY:

Status	Date	Action
New	3/10/2025	New policy

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. BSWHP will continue to review clinical evidence related to this policy and make modifications based upon the evolution of the published clinical evidence. Should additional scientific studies become available, and they are not included in the list, please forward the reference(s) to BSWHP so the information can be

reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. Roddie, C., et al. (2024). Obecabtagene Autoleucel in Adults with B-Cell Acute Lymphoblastic Leukemia. *The New England journal of medicine*, *391*(23), 2219–2230. https://doi.org/10.1056/NEJMoa2406526

2. *FDA approves Obecabtagene Autoleucel for acute lymphoblastic leukemia* (2024) *U.S. Food and Drug Administration*. Available at: https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-obecabtagene-autoleucel-adults-relapsed-or-refractory-b-cell-precursor-acute (Accessed: 17 December 2024).

3. Prescribing Label: AUTOLUS (obecabtagene autoleucel) suspension for intravenous infusion. Autolus Inc., Available at: https://www.fda.gov/media/183463/download?attachment. Accessed December 2024.

4. *Aucatzyl (obecabtagene autoleucel) suspension for intravenous infusion by Autolus (2024) IPD Analytics NOC Code Guide: Aucatzyl CAR T-Cell Immunotherapy for the Treatment of Acute Lymphoblastic Leukemia.*

5. *Formulary Dossier of Clinical and Economic Evidence for the Consideration of: Obecabtagene Autoleucel (obe-cel) (2024) Autolus Ltd.*

***Note**:*
Health Maintenance Organization (HMO) products are offered through Scott and White Health Plan dba Baylor Scott & White Health Plan, and Scott & White Care Plans dba Baylor Scott & White Care Plan. Insured PPO and EPO products are offered through Baylor Scott & White Insurance Company. Scott and White Health Plan dba Baylor Scott & White Health Plan serves as a third-party administrator for self-funded employer-sponsored plans. Baylor Scott & White Care Plan and Baylor Scott & White Insurance Company are wholly owned subsidiaries of Scott and White Health Plan. These companies are referred to collectively in this document as Baylor Scott & White Health Plan.

RightCare STAR Medicaid is offered through Scott and White Health Plan in the Central Texas Medicaid Rural Service Area (MRSA); FirstCare STAR is offered through SHA LLC dba FirstCare Health Plans (FirstCare) in the Lubbock and West MRSAs; and FirstCare CHIP is offered through FirstCare in the Lubbock Service Area.