

**Clinical Policy: Gemtuzumab Ozogamicin (Mylotarg)**

Reference Number: CP.PHAR.358

Effective Date: 10.03.17

Last Review Date: 11.19

Line of Business: Commercial, Medicaid, HIM-Medical Benefit

[Coding Implications](#)[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

**Description**

Gemtuzumab ozogamicin (Mylotarg<sup>™</sup>) is a CD33 directed antibody-drug conjugate.

**FDA Approved Indication(s)**

Mylotarg is indicated for the treatment of:

- Newly-diagnosed CD33-positive acute myeloid leukemia (AML) in adults
- Relapsed or refractory CD33-positive AML in adults and in pediatric patients 2 years and older

**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 health plans affiliated with Centene Corporation<sup>®</sup> that Mylotarg is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria****A. Acute Myeloid Leukemia (must meet all):**

1. Diagnosis of CD33-positive AML;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Member meets (a or b):
  - a. Age  $\geq$  18 years with newly diagnosed disease;
  - b. Age  $\geq$  2 years with relapsed or refractory disease;
4. Request meets one of the following (a or b):\*
  - a. Newly diagnosed disease as combination therapy with daunorubicin and cytarabine: dose does not exceed 3 mg/m<sup>2</sup> (up to one 4.5 vial) on Days 1, 4, and 7 (induction - 1 cycle containing Mylotarg) and 3 mg/m<sup>2</sup> (up to one 4.5 mg vial) on Day 1 (consolidation - 2 cycles);
  - b. Newly diagnosed disease as single-agent therapy: dose does not exceed 6 mg/m<sup>2</sup> on Day 1, and 3 mg/m<sup>2</sup> on Day 8 (induction - 1 cycle) and 2 mg/m<sup>2</sup> on Day 1 every 4 weeks (continuation - up to 8 cycles);
  - c. Relapsed or refractory disease as single-agent therapy: dose does not exceed 3 mg/m<sup>2</sup> (up to one 4.5 mg vial) on Days 1, 4 and 7 (1 cycle);
  - d. 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 (Up to a total of 10 doses)**

**B. Acute Promyelocytic Leukemia (off-label) (must meet all):**

1. Diagnosis of acute promyelocytic leukemia;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age  $\geq$  2 years;
4. Dose is within FDA maximum limit for any FDA-approved indication or 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 (Up to a total of 10 doses)**

**C. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid and HIM-Medical Benefit.

**II. Continued Therapy**

**A. All Indications in Section I (must meet all):**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Mylotarg for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For AML, member has NOT received the maximum recommended doses as described below (a, b or c):
  - a. As combination therapy with daunorubicin and cytarabine for newly diagnosed disease: up to 5 doses;
  - b. As single-agent therapy for newly diagnosed disease: up to 10 doses;
  - c. As single-agent therapy for relapsed or refractory disease: up to 3 doses;
4. If request is for a dose increase, request meets one of the following (a, b, c, or d):\*
  - a. Newly diagnosed disease as combination therapy with daunorubicin and cytarabine: new dose does not exceed 3 mg/m<sup>2</sup> (up to one 4.5 vial) on Days 1, 4, and 7 (induction - 1 cycle containing Mylotarg) and 3 mg/m<sup>2</sup> (up to one 4.5 mg vial) on Day 1 (consolidation - 2 cycles);
  - b. Newly diagnosed disease as single-agent therapy: new dose does not exceed 6 mg/m<sup>2</sup> on Day 1, and 3 mg/m<sup>2</sup> on Day 8 (induction - 1 cycle) and 2 mg/m<sup>2</sup> on Day 1 every 4 weeks (continuation - up to 8 cycles);
  - c. Relapsed or refractory disease as single-agent therapy: new dose does not exceed 3 mg/m<sup>2</sup> (up to one 4.5 mg vial) on Days 1, 4 and 7 (1 cycle);
  - d. 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 (Approve requested number of doses required to complete therapy and not to exceed a total of 10 doses)**

**B. Other diagnoses/indications (must meet 1 or 2):**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

**Approval duration: Duration of request or 6 months (whichever is less); or**

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid and HIM-Medical Benefit.

**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 and CP.PMN.53 for Medicaid and HIM-Medical Benefit or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

AML: acute myeloid leukemia

FDA: Food and Drug Administration

NCCN: National Comprehensive Cancer Center

*Appendix B: Therapeutic Alternatives*

Not applicable

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): hypersensitivity
- Boxed warning(s): hepatotoxicity

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
AML newly-diagnosed (combination regimen)	<p><i>Induction:</i> 3 mg/m<sup>2</sup> IV (up to one 4.5 mg vial) on Days 1, 4, and 7 in combination with daunorubicin and cytarabine. If a second induction cycle is required, do NOT administer Mylotarg.</p> <p><i>Consolidation:</i> 3 mg/m<sup>2</sup> IV on Day 1 (up to one 4.5 mg vial) in combination with daunorubicin and cytarabine for 2 cycles.</p>	<p><i>Induction:</i> 4.5 mg/dose (1 cycle)</p> <p><i>Consolidation:</i> 4.5 mg/dose (2 cycles)</p>
AML newly-diagnosed (single-agent regimen)	<p><i>Induction:</i> 6 mg/m<sup>2</sup> IV on Day 1 and 3 mg/m<sup>2</sup> on Day 8 for 1 cycle</p> <p><i>Continuation:</i> 2 mg/m<sup>2</sup> IV on Day 1 every 4 weeks for up to 8 cycles</p>	<p><i>Induction:</i> 6 mg/m<sup>2</sup>/dose (1 cycle)</p> <p><i>Maintenance:</i> 2 mg/m<sup>2</sup>/dose every 4 weeks (8 cycles)</p>

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Indication	Dosing Regimen	Maximum Dose
AML relapsed or refractory (single-agent regimen)	3 mg/m <sup>2</sup> IV (up to one 4.5 mg vial) on Days 1, 4, and 7 for 1 cycle	4.5 mg/dose (1 cycle)

**VI. Product Availability**

Single-dose vial: 4.5 mg

**VII. References**

1. Mylotarg Prescribing Information. Wyeth Pharmaceuticals Inc.; Philadelphia, PA. April 2018. Available at: [www.mylotarg.com](http://www.mylotarg.com). Accessed August 8, 2019.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: [http://www.nccn.org/professionals/drug\\_compendium](http://www.nccn.org/professionals/drug_compendium). Accessed July 22, 2019.
3. National Comprehensive Cancer Network. Acute Myeloid Leukemia Version 3.2019. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/aml.pdf](https://www.nccn.org/professionals/physician_gls/pdf/aml.pdf). Accessed July 22, 2019.

**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
J9203	Injection, gemtuzumab ozogamicin, 0.1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	10.03.17	11.17
4Q 2018 annual review: added HIM-Medical; added prescriber requirement; added COC language; for acute promyelocytic leukemia, added age limit and removed requirement for use only for relapse as NCCN compendia include use for induction and consolidation; references reviewed and updated.	07.18.18	11.18
4Q 2019 annual review: FDA/NCCN dosage limitations added; references reviewed and updated.	08.20.19	11.19

**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

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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.

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**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.

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