Reference number(s)
2265-A

STANDARD MEDICARE PART B MANAGEMENT

BESPONSA (inotuzumab ozogamicin)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indication
Besponsa is indicated for the treatment of adults with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL).

B. Compendial Use
Pediatric acute lymphoblastic leukemia (ALL)

All other indications will be assessed on an individual basis. Submissions for indications other than those enumerated in this policy should be accompanied by supporting evidence from Medicare approved compendia.

II. DOCUMENTATION

The following documentation must be available, upon request, for all submissions: Testing or analysis confirming CD22 protein on the surface of the B-cell.

III. CRITERIA FOR INITIAL APPROVAL

Acute lymphoblastic leukemia (ALL)

A. Authorization of 12 months may be granted for treatment of ALL as induction therapy when all of the following criteria are met:
   1. Member has B-cell precursor ALL
   2. The tumor is CD22-positive as confirmed by testing or analysis to identify the CD22 protein on the surface of the B-cell
   3. Member has Philadelphia chromosome-negative disease
   4. Member is at least 65 years old or has substantial comorbidities
   5. The requested drug will be used in combination with cyclophosphamide, dexamethasone, vincristine, methotrexate and cytarabine
   6. Member will not receive more than 6 treatment cycles of the requested drug

B. Authorization of 12 months may be granted for treatment of relapsed or refractory ALL when all of the following criteria are met:
   1. Member has B-cell precursor ALL.
   2. The tumor is CD22-positive as confirmed by testing or analysis to identify the CD22 protein on the surface of the B-cell.

3. Member meets one of the following:
   i. Member has Philadelphia chromosome-positive disease
   ii. Member has Philadelphia chromosome-negative disease
4. The requested drug will be used in one of the following settings:
   i. As a single agent
   ii. In combination with a tyrosine kinase inhibitor for Philadelphia chromosome-positive disease (e.g., imatinib, dasatinib, nilotinib, bosutinib, ponatinib)
   iii. In combination with cyclophosphamide, dexamethasone, vincristine, methotrexate, and cytarabine with or without blinatumomab
5. Member will not receive more than 6 treatment cycles of the requested drug.

IV. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must be currently receiving therapy with the requested agent.

Authorization for 12 months may be granted when all of the following criteria are met:
A. The member is currently receiving therapy with the requested drug.
B. The requested drug is being used to treat an indication enumerated in Section III.
C. The member is receiving benefit from therapy. Benefit is defined as:
   i. No evidence of unacceptable toxicity while on the current regimen AND
   ii. No evidence of disease progression while on the current regimen.
D. Member has not/will not receive more than 6 treatment cycles of the requested drug.

V. SUMMARY OF EVIDENCE

The contents of this policy were created after examining the following resources:
1. The prescribing information for Besponsa.
2. The available compendium
   a. National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
   b. Micromedex DrugDex
   c. American Hospital Formulary Service- Drug Information (AHFS-DI)
   d. Lexi-Drugs
   e. Clinical Pharmacology
3. NCCN Guideline: Pediatric acute lymphoblastic leukemia
4. NCCN Guideline: Acute lymphoblastic leukemia

After reviewing the information in the above resources, the FDA-approved indications listed in the prescribing information for Besponsa are covered in addition to pediatric acute lymphoblastic leukemia.

VI. EXPLANATION OF RATIONALE

Support for FDA-approved indications can be found in the manufacturer's prescribing information.

Support for using Besponsa to treat pediatric acute lymphoblastic leukemia can be found in the NCCN Drugs and Biologics Compendium. Use of information in the NCCN Drugs and Biologics Compendium for off-label use of drugs and biologicals in an anti-cancer chemotherapeutic regimen is supported by the Medicare Benefit Policy Manual, Chapter 15, section 50.4.5 (Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen).

VII. REFERENCES

1. Besponsa [package insert]. Philadelphia, PA: Wyeth Pharmaceuticals LLC, Inc.; March 2018.
2. Kantarjian Hagop M, DeAngelo Daniel J., Stelljes Matthias, et al. Inotuzumab Ozogamicin versus Standard Therapy for Acute Lymphoblastic Leukemia. *N Engl J Med.* 2016; 375: 740-53
3. The NCCN Drugs & Biologics Compendium® © 2023 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed April 5, 2023.