



## Medical Policy Manual

**Draft Revised Policy: Do Not Implement**

### Tagraxofusp-erzs (Elzonris®)

#### IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

#### 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

Elzonris is a CD123-directed cytotoxin indicated for the treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN) in adults and in pediatric patients 2 years and older.

B. Compendial Use

Blastic plasmacytoid dendritic cell neoplasm (BPDCN)

All other indications are considered experimental/investigational and not medically necessary.

##### II. DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review: Medical record documentation **that supports a confirmed diagnosis of BPDCN.** ~~confirming the member is positive for CD123 expression~~

##### III. CRITERIA FOR INITIAL APPROVAL

###### **Blastic plasmacytoid dendritic cell neoplasm (BPDCN)**

Authorization of 12 months may be granted for treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN) ~~when the member's disease is positive for CD123 expression and the requested medication will be used as a single agent.~~

##### IV. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in Section III when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

#### **APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS**

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-



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label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

### ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

### REFERENCES

1. Elzonris [package insert]. New York, NY: Stemline Therapeutics, Inc.; July 2023.
2. The NCCN Drugs & Biologics Compendium® © 2024 National Comprehensive Cancer Network, Inc. <https://www.nccn.org>. Accessed January 6, 2024.

### EFFECTIVE DATE

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