Besponsa™ (inotuzumab ozogamicin)
(Intravenous)

Document Number: IC-0317

Last Review Date: 10/24/2022
Date of Origin: 09/19/2017
Dates Reviewed: 09/2017, 11/2018, 11/2019, 11/2020, 11/2021, 11/2022

I. Length of Authorization

Coverage will be provided for 6 months (for up to a maximum of 6 cycles) and may not be renewed.

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

- Besponsa 0.9 mg powder for injection single-dose vial: 7 vials per 21 days

B. Max Units (per dose and over time) [HCPCS Unit]:

Cycle 1

- 27 billable units (2.7 mg) on Day 1, 18 billable units (1.8 mg) on Days 8 and 15 of a 21 to 28-day cycle

Subsequent Cycles (maximum of 5 cycles)

- 27 billable units (2.7 mg) on Day 1, 18 billable units (1.8 mg) on Days 8 and 15 of a 28-day cycle for up to 2 cycles
- 18 billable units (1.8 mg) on Day 1, Day 8, and Day 15 of a 28-day cycle for up to 3 cycles

III. Initial Approval Criteria [1]

Coverage is provided in the following conditions:

- Baseline electrocardiogram (ECG) is within normal limits; **AND**
- Patient has not previously received treatment with inotuzumab ozogamicin; **AND**

Universal Criteria [1-3]

- Patient has CD22-positive disease; **AND**

Adult B-Cell Precursor Acute Lymphoblastic Leukemia (ALL) † Φ [1-3]

- Patient is at least 18 years of age; **AND**
  - Patient has relapsed or refractory disease; **AND**

- Used as single agent therapy; **OR**
- Used in combination with mini-hyper CVD (cyclophosphamide, dexamethasone, vincristine, methotrexate, cytarabine); **AND**
  - Patient is Philadelphia chromosome (Ph)-negative; **OR**
  - Patient is Philadelphia chromosome (Ph)-positive and refractory to prior tyrosine kinase inhibitor therapy (e.g., imatinib, dasatinib, ponatinib, nilotinib, bosutinib, etc.); **OR**
- Used in combination with tyrosine kinase inhibitor (TKI) therapy (e.g., bosutinib, dasatinib, imatinib, nilotinib, or ponatinib); **AND**
  - Patient is Philadelphia chromosome (Ph)-positive; **OR**

o Used as induction therapy in patients ≥65 years of age or with substantial comorbidities; **AND**
- Used in combination with mini-hyper CVD; **AND**
- Patient is Philadelphia chromosome (Ph)-negative

Pediatric B-Cell Precursor Acute Lymphoblastic Leukemia (ALL) ‡ [3,4]

- Patient is at least 2 years of age; **AND**
- Patient has relapsed or refractory disease; **AND**
- Used as single agent therapy; **AND**
  - Patient is Philadelphia chromosome (Ph)-negative; **OR**
  - Patient is Philadelphia chromosome (Ph)-positive; **AND**
    - Patient is intolerant or refractory to prior tyrosine kinase inhibitor (TKI) therapy (e.g., imatinib, dasatinib, etc.)

† FDA Approved Indication(s); ‡ Compendium Recommended Indication(s); Φ Orphan Drug

IV. Renewal Criteria [1]

Coverage cannot be renewed.

V. Dosage/Administration [1]

Indication	Dose
B-Cell Precursor ALL	**Cycle 1:** • 1.8 mg/m² total per cycle, administered as 3 divided doses on Day 1 (0.8 mg/m²), Day 8 (0.5 mg/m²), and Day 15 (0.5 mg/m²) • Cycle 1 is 3 weeks in duration, but may be extended to 4 weeks if the patient achieves CR or CRi, and/or to allow recovery from toxicity **Subsequent Cycles (cycles are 4 weeks in duration):** CR or CRi achieved • 1.5 mg/m² total per cycle, administered as 3 divided doses on Day 1 (0.5 mg/m²), Day 8 (0.5 mg/m²), and Day 15 (0.5 mg/m²)

	Did not achieve CR or CRi • 1.8 mg/m^2 total per cycle, administered as 3 divided doses on Day 1 (0.8 mg/m^2), Day 8 (0.5 mg/m^2), and Day 15 (0.5 mg/m^2) • Patients who do not achieve a CR or CRi within 3 cycles should discontinue treatment. **Patients proceeding to HSCT:** • Recommended duration of treatment is 2 cycles • A third cycle may be considered for those patients who do not achieve CR or CRi and MRD negativity after 2 cycles **Patients not proceeding to HSCT:** • Additional cycles of treatment, up to a maximum of 6 cycles, may be administered
CR (complete remission); CRi (complete remission with incomplete hematologic recovery); HSCT (hematopoietic stem cell transplant); MRD (minimal residual disease)	

VI. Billing Code/Availability Information

HCPCS Code:

- J9229 – Injection, inotuzumab ozogamicin, 0.1 mg: 1 billable unit = 0.1 mg

NDC:

- Besponsa 0.9 mg lyophilized powder in single-dose vial: 00008-0100-xx

VII. References

1. Besponsa [package insert]. Philadelphia, PA; Pfizer Inc., March 2018. Accessed September 2022.
2. Kantarjian HM, DeAngelo DJ, Stelljes M, et al. Inotuzumab Ozogamicin versus Standard Therapy for Acute Lymphoblastic Leukemia. N Engl J Med. 2016 Aug 25;375(8):740-53.
3. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) inotuzumab ozogamicin. National Comprehensive Cancer Network, 2022. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed September 2022.
4. Bhojwani D, Sposto R, Shah NN, et al. Inotuzumab ozogamicin in pediatric patients with relapsed/refractory acute lymphoblastic leukemia [published correction appears in Leukemia. 2019 Mar 7;:]. Leukemia. 2019;33(4):884–892. doi:10.1038/s41375-018-0265-z.

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
C83.50	Lymphoblastic (diffuse) lymphoma, unspecified site
C83.51	Lymphoblastic (diffuse) lymphoma, lymph nodes of head, face, and neck

C83.52	Lymphoblastic (diffuse) lymphoma, intrathoracic lymph nodes
C83.53	Lymphoblastic (diffuse) lymphoma, intra-abdominal lymph nodes
C83.54	Lymphoblastic (diffuse) lymphoma, lymph nodes of axilla and upper limb
C83.55	Lymphoblastic (diffuse) lymphoma, lymph nodes of inguinal region and lower limb
C83.56	Lymphoblastic (diffuse) lymphoma, intrapelvic lymph nodes
C83.57	Lymphoblastic (diffuse) lymphoma, spleen
C83.58	Lymphoblastic (diffuse) lymphoma, lymph nodes of multiple sites
C83.59	Lymphoblastic (diffuse) lymphoma, extranodal and solid organ sites
C91.00	Acute lymphoblastic leukemia not having achieved remission
C91.01	Acute lymphoblastic leukemia, in remission
C91.02	Acute lymphoblastic leukemia, in relapse

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Articles (LCAs), and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCA/LCD): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC

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PCHP:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact a Grievance Specialist.

If you believe that PCHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance Specialist
PreferredOne Community Health Plan
PO Box 59052
Minneapolis, MN 55459-0052
Phone: 1.800.940.5049 (TTY: 763.847.4013)
Fax: 763.847.4010
customerservice@preferredone.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.800.940.5049 (TTY: 763.847.4013).

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PreferredOne Insurance Company
PO Box 59212
Minneapolis, MN 55459-0212
Phone: 1.800.940.5049 (TTY: 763.847.4013)
Fax: 763.847.4010
customerservice@preferredone.com

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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