

PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Injectable – CAR-T) – Aucatzyl Prior Authorization Policy

- Aucatzyl® (obecabtagene autoleucel intravenous infusion – Autolus)

REVIEW DATE: 11/20/2024

OVERVIEW

Aucatzyl, a CD19-directed genetically modified autologous T cell immunotherapy, is indicated for the treatment of relapsed or refractory **B-cell precursor acute lymphoblastic leukemia** in adults.¹

Guidelines

The National Comprehensive Cancer Network ALL (version 3.2024 – December 20, 2024) guidelines recommend Aucatzyl for the treatment of relapsed or refractory Philadelphia chromosome negative B-cell ALL as a “Preferred Regimen” (category 2A) and Philadelphia chromosome positive B-cell ALL following treatment with a tyrosine kinase inhibitor as an “Other Recommended Regimen” (category 2A).^{2,3}

Safety

Aucatzyl has a Boxed Warning concerning cytokine release syndrome, neurologic toxicity including immune effector cell-associated neurotoxicity syndrome, and secondary hematological malignancies.¹

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Aucatzyl. Because of the specialized skills required for evaluation and diagnosis of patients treated with Aucatzyl as well as the monitoring required for adverse events and long-term efficacy, approval requires Aucatzyl to be prescribed by or in consultation with a physician who specializes in the condition being treated. The Approval duration is 6 months to allow for an adequate time frame to prepare and administer 1 dose of therapy.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Aucatzyl is recommended in those who meet the following criteria:

FDA-Approved Indications

- 1. Acute Lymphoblastic Leukemia.** Approve a single dose if the patient meets ALL of the following (A, B, C, D, E, and F):
 - A)** Patient is ≥ 18 years of age; AND
 - B)** Patient has B-cell precursor disease; AND
 - C)** Patient has relapsed or refractory disease; AND
 - D)** Patient received or plans to receive lymphodepleting chemotherapy prior to infusion of Aucatzyl; AND
 - E)** Patient has not been previously treated with CAR-T therapy; AND

Note: Examples of CAR-T therapy include Aucatzyl, Tecartus (brexucabtagene autoleucel intravenous infusion), Breyanzi (lisocabtagene maraleucel intravenous infusion), Kymriah
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(tisagenlecleucel intravenous infusion), Yescarta (axicabtagene intravenous infusion) and Abecma (idecabtagene vicleucel intravenous infusion).

F) Aucatzyl is prescribed by or consultation with an oncologist.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Aucatzyl is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Aucatzyl intravenous infusion [prescribing information]. Gaithersburg, MD: Autolus; November 2024.
2. The NCCN Drugs and Biologics Compendium. © 2024 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on December 27, 2024. Search term: obecabtagene.
3. The NCCN Acute Lymphoblastic Leukemia Clinical Practice Guidelines in Oncology (version 3.2024 – December 20, 2024). © 2024 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on December 27, 2024.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	11/20/2024
DEU Update	12/27/2024: Updated the Guideline section of the policy with National Comprehensive Cancer Network recommendations for Aucatzyl.	N/A