Besponsa™ (inotuzumab ozogamicin)
(Intravenous)

Document Number: IC-0317

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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: 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 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 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 is intolerant or refractory to prior tyrosine kinase inhibitor therapy (e.g., imatinib, dasatinib, ponatinib, nilotinib, bosutinib, etc.); **OR**
- Used in combination with bosutinib; **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 is intolerant or refractory to prior tyrosine kinase inhibitor therapy (e.g., imatinib, dasatinib, etc.)

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

IV. Renewal Criteria

Coverage cannot be renewed.

V. Dosage/Administration

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/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)

	• 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 units = 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 October 2021.
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, 2021. 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 October 2021.
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/Aw

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