

EVH Clinical Guideline 5070.CC for Zynteglo (betibeglogene autotemcel)

Guideline Number: EVH_CG_5070.CC	<u>Applicable Codes</u>	
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STATEMENT

General Information

- *It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity and approval by the Medical Policy Committee.*
- *If the established criteria are not met, the request is referred to a Medical Director for review, if required for the plan and level of request.*

Purpose

The purpose of this guideline is to define the prior authorization process for the following drug: Zynteglo (betibeglogene autotemcel).

Scope

This guideline applies to all practitioners who are involved in providing the requested drug. This guideline is specific to the Health Plan's medical benefit.

INITIAL REVIEW CRITERIA

The request must meet all of the criteria listed below.

- Must be prescribed by, or in consultation with, a hematologist or transplant specialist
- Member is ≥ 4 years of age and < 65 years of age
- Must have a diagnosis of β -thalassemia confirmed by genetic testing
- Must be transfusion dependent as evidenced by ONE of the following occurring within the last 2 years preceding this request:
 - History of receiving at least 100 mL/kg/year of packed red blood cells (pRBCs) transfusions
 - History of ≥ 8 transfusions of pRBCs per year
- Must submit laboratory screening/results or imaging documentation of ALL the following, **collected within the last 3 months**:
 - Negative HIV-1 and HIV-2 screening
 - Negative hepatitis B and C screening
 - Negative Human T lymphocytic virus type (HTLV) 1 or 2
 - Complete Blood Count (CBC) with white blood cell (WBC) count $> 3 \times 10^9/L$ and platelet count $> 100 \times 10^9$

- **EXCEPTION:** If CBC results are below thresholds, results can be acceptable if attributable to hypersplenism
- Baseline creatinine clearance ≥ 70 mL/min/1.73m²
- Liver function tests and any associated imaging that rules out advanced liver disease (i.e., bridging fibrosis, cirrhosis, active hepatitis)
- MRI scan of the liver
 - **Members ≥ 18 years of age:** If the MRI results demonstrate liver iron content ≥ 15 mg/g, liver biopsy results are required to rule out advanced liver disease
 - **Members < 18 years of age:** If the MRI results demonstrate liver iron content ≥ 15 mg/g, the request is denied
- MRI scan of the heart showing a cardiac T2* > 10 ms
- Diffuse capacity of carbon monoxide (DLCO) $> 50\%$ predicted
- Must have chart note documentation or an attestation from the provider of all the following:
 - The member does not have hemoglobin S/ β -thalassemia or α -thalassemia
 - If applicable, antiretrovirals and hydroxyurea will be discontinued at least 1 month prior to mobilization and until all cycles of apheresis have been completed
 - If applicable, iron chelation therapy will be discontinued at least 7 days prior to initiation of conditioning
 - If member is female of child-bearing age: a negative serum pregnancy test will be confirmed prior to the start of mobilization and re-confirmed prior to conditioning procedures and before ZYNTGLO administration
 - The member does not have a history of an uncontrolled bleeding disorder
 - The member does not have any prior or current malignancies OR myeloproliferative or significant immunodeficiency disorders
 - The member does not have an immediate family member with a known Familial Cancer Syndrome
 - The member does not have an uncontrolled seizure disorder
 - The member does not have a clinically significant and active bacterial, viral, fungal, or parasitic infection
 - The member has not received prior gene therapy or a hematopoietic stem cell transplant

REAUTHORIZATION CRITERIA

Zynteglo is not eligible for reauthorization as only a single course is allowed per member's lifetime.

APPROVAL DURATIONS

Initial Authorization	Six months
Reauthorization	N/A

CODING AND STANDARDS

Codes

Code	Brand	Description
J3393	Zynteglo	Injection, betibeglogene autotemcel, per treatment

Applicable Lines of Business

☐	CHIP (Children's Health Insurance Program)
☐	Commercial
☐	Exchange/Marketplace
☒	Medicaid
☐	Medicare Advantage

BACKGROUND

The purpose of this policy is to define the prior authorization process for Zynteglo (betibeglogene autotemcel) for the treatment of adult and pediatric patients with β -thalassemia who require regular red blood cell (RBC) transfusions.

POLICY HISTORY

Date	Summary
July 2026	Annual Review
August 2024	New guideline

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Administrative Services Medical Policy Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

REFERENCES

American Medical Association (11th edition) with superscripted numbers in parentheses for in-text citations.

1. Zynteglo [package insert]. Somerville, MA: bluebird bio, Inc.; August 2022.
2. Locatelli F, Thompson AA, Kwiatkowski JL, et al. Betibeglogene autotemcel gene therapy for non- β^0/β^0 genotype β -thalassemia. N Engl J Med. 2022;386(5):415-427. doi:10.1056/NEJMoa2113206 [PubMed [34891223](https://pubmed.ncbi.nlm.nih.gov/34891223/)]