| Brentuximab vedotin (Adcetris®) | Place of Service<br>Office Administration<br>Outpatient Facility Infusion Administration<br>Infusion Center Administration<br><br>HCPCS: J9042 per 1 mg |
|---|---|

**Condition(s) listed in policy (*see criteria for details*)**

- Adult T-cell leukemia/lymphoma (acute or lymphoma subtypes)
- B-cell lymphoma *(see section for specific types covered)*
- CD30+ peripheral T-cell lymphoma (PTCL) *(see section for specific types covered)*
- CD30+ primary cutaneous T-cell lymphoproliferative disorders [cutaneous ALCL or lymphomatoid papulosis (LyP)]
- Extranodal NK/T-cell lymphoma
- Hepatosplenic gamma-delta T-cell lymphoma
- Hodgkin lymphoma, previously untreated
- Hodgkin lymphoma, post autologous HSCT consolidation therapy
- Hodgkin lymphoma, relapsed/refractory
- Mycosis fungoides or sezary syndrome

**AHFS therapeutic class:** Antineoplastic agents

**Mechanism of action:** Brentuximab vedotin is an injectable antibody drug conjugate (ADC) directed at CD30.

## (1) Special Instructions and Pertinent Information

**Covered under the medical benefit,** please submit clinical information for prior authorization review via fax.

## (2) Prior Authorization/Medical Review is required for the following condition(s)

**All requests for Adcetris® (brentuximab vedotin) must be sent for clinical review and receive authorization prior to drug administration or claim payment.**

### Adult T-Cell leukemia/lymphoma (acute or lymphoma subtypes)

**Covered dose**
Up to 1.8 mg/kg IV every 3 weeks

**Coverage period**
Indefinite

**ICD-10**:
C91.50, C91.51, C91.52

### B-cell lymphoma

1. Diagnosis is one of the following subtypes:
    a. Diffuse large B-cell lymphoma
    b. Follicular lymphoma
    c. High-grade B-cell lymphomas

d. Histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma
e. HIV-related B-cell lymphomas
f. Post-transplant lymphoproliferative disorders
g. Primary mediastinal large B-cell lymphoma

**Covered Doses**
Up to 1.8 mg/kg IV every 3 weeks

**Coverage Period**
Indefinite

**ICD-10:**
C82.00-C82.09, C82.10-C82.19, C82.20-C82.29, C82.30-C82.39, C82.40-C82.49, C82.50-C82.59, C82.60-C82.69, C82.80-C82.89, C82.90-C82.99, C83.30-C83.39, C85.10 - C85.19, C85.20-C85.29, C83.90-C83.99, D47.Z1
OR
B20 AND C83.30-C83.39, C83.80-C83.89, C83.90-C83.99, C85.80-C85.89

**CD30+ Peripheral T-cell lymphoma (PTCL)**

1. Diagnosis of one of the following subtypes: CD30+ peripheral T-cell lymphoma (not otherwise specified), anaplastic large cell lymphoma, angioimmunoblastic T-cell lymphoma, enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with TFH phenotype, and follicular T-cell lymphoma.

**Covered Doses**
Up to 1.8 mg/kg IV every 3 weeks

**Coverage Period**
Indefinite

**ICD-10:** C86.2, C84.40-C84.49, C84.60-C84.69, C84.70-C84.79, C86.2, C86.5

**CD30+ Primary cutaneous T-cell lymphoproliferative disorders [cutaneous ALCL or lymphomatoid papulosis (LyP)]**

1. Either of the following:
   a. CD30+ cutaneous anaplastic large cell lymphoma, or
   b. CD30+ lymphomatoid papulosis (LyP) as single agent therapy

**Covered Doses**
Up to 1.8 mg/kg IV every 3 weeks

**Coverage Period**
Indefinite

**ICD-10:** C84.60

**Extranodal NK/T-cell lymphoma**

**Covered dose**
Up to 1.8 mg/kg IV every 3 weeks

**Coverage period**
Indefinite

**ICD-10**:
C84,99, C86.0

**Hepatosplenic gamma-delta T-cell lymphoma**

**Covered dose**
Up to 1.8 mg/kg IV every 3 weeks

**Coverage period**
Indefinite

**ICD-10**:
C86.1

**Hodgkin lymphoma, previously untreated**

1. One of the following:
    a. Stage I or II unfavorable and patient is 60 years of age or older, or
    b. Stage III or IV, or
    c. Provider attestation of high-risk disease in a pediatric patient

    **AND**
2. Being used in combination with chemotherapy

**Covered Doses**
1.2 mg/kg (max of 120 mg) every 2 weeks or
1.8 mg/kg (max of 180 mg) every 3 weeks

**Coverage Period**
Indefinitely

**ICD-10:**
C81.10-C81.19, C81.20-C81.29, C81.30-C81.39, C81.40-C81.49, C81.70-C81.79, C81.90-C81.99

**Hodgkin lymphoma, post autologous HSCT consolidation therapy**

1. Single agent therapy, **AND**
2. Administered following autologous stem cell rescue in patients with high risk of relapse or progression

**Covered Doses**
Up to 1.8 mg/kg IV every 3 weeks

**Coverage Period**
Indefinite

**ICD-10:** C81.10-C81.19, C81.20-C81.29, C81.30-C81.39, C81.40-C81.49, C81.70-C81.79, C81.90-

C81.99, Z85.71, OR
30233X0, 30233Y0 (autologous stem cell transplant peripheral)

**Hodgkin lymphoma, relapsed/refractory disease**

1. Disease relapsed or is refractory after prior treatment (e.g., autologous stem cell transplant [ASCT], chemotherapy), **AND**
2. One of the following:
   a. Being used as single agent therapy, or
   b. Being used in combination with bendamustine, nivolumab, or gemcitabine, or
   c. Being used in combination with ICE (ifosfamide, carboplatin, etoposide)

**Covered Doses**
Up to 1.8 mg/kg IV every 3 weeks

**Coverage Period**
Indefinite

**ICD-10:** C81.10-C81.19, C81.20-C81.29, C81.30-C81.39, C81.40-C81.49, C81.70-C81.79, C81.90-C81.99, Z85.71

**Mycosis Fungoides (MF) or Sezary Syndrome (SS)**

1. Not being used in combination with other systemic therapies

**Covered Doses**
Up to 1.8 mg/kg IV every 3 weeks

**Coverage Period**
Indefinite

**ICD-10:** C84.00-C84.09, C84.10-C84.19

**(3) The following condition(s) DO NOT require Prior Authorization/Preservice**

**All requests for Adcetris® (brentuximab vedotin) must be sent for clinical review and receive authorization prior to drug administration or claim payment.**

**(4) This Medication is NOT medically necessary for the following condition(s)**

Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

**(5) Additional Information**

How supplied: 50 mg (single-use vial)

**(6) References**


- Adcetris® (brentuximab) [Prescribing Information]. Bothell, WA: Seagen Inc., 11/2022.
- AHFS®. Available by subscription at http://www.lexi.com

- DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
- National Comprehensive Cancer Network Drugs & Biologics Compendium. Adcetris® (2023). Available by subscription at: www.nccn.org
- National Comprehensive Cancer Network. B-Cell Lymphomas (Version 2.2023). Available at: www.nccn.org.
- National Comprehensive Cancer Network. Hodgkin Lymphoma (Version 2.2023). Available at: www.nccn.org
- National Comprehensive Cancer Network. Pediatric Hodgkin Lymphoma (Version 2.2023). Available at: www.nccn.org.
- National Comprehensive Cancer Network. Primary Cutaneous Lymphomas (Version 1.2023). Available at: www.nccn.org.
- National Comprehensive Cancer Network. T-Cell Lymphomas (Version 1.2023). Available at: www.nccn.org.


## (7) Policy Update

Date last review: 2Q2023
Date of next review: 2Q2024
Changes from previous policy version:

- Section (2): B-cell lymphoma – Added coverage for primary mediastinal large B-cell lymphoma
  *Rationale: NCCN category 2A support*

*BSC Drug Coverage Criteria to Determine Medical Necessity*
*Reviewed by P&T Committee*