

Tagraxofusp-erzs (Elzonris®)

Place of Service

Hospital Administration

Office Administration

Outpatient Facility Infusion Administration

Infusion Center Administration

HCPSC: J9269 per 10 mcg

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

- [Blastic plasmacytoid dendritic cell neoplasm \(BPDCN\)](#)

AHFS therapeutic class: antineoplastic

Mechanism of action: CD123-directed cytotoxin

(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 tagraxofusp-erzs (Elzonris®) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

Blastic plasmacytoid dendritic cell neoplasm (BPDCN)

Covered Dose

Up to 12 mcg/kg IV once daily on days 1 to 5 of 21-day cycles. The dosing period may be extended for dose delays up to day 10 of the cycle

Coverage period

Indefinite

ICD-10:

C86.4

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

All requests for tagraxofusp-erzs (Elzonris®) 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:

1000 mcg/1 mL (single-dose vial)

(6) References

- AHFS®. Available by subscription at <http://www.lexi.com>
- DrugDex®. Available by subscription at <http://www.micromedexsolutions.com/home/dispatch>
- Elzonris (tagraxofusp-erzs) [Prescribing Information]. New York, NY: Stemline Therapeutics; 11/2022.
- National Comprehensive Cancer Network. Acute myeloid leukemia (Version 2.2023). Available at: www.nccn.org.

(7) Policy Update

Date of last review: 2Q2023

Date of next review: 2Q2024

Changes from previous policy version:

- No clinical change to policy following routine annual review.

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