JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Pharmacy Public** **Medical Management Drug Policies**	*Policy Number*	MMDP102
		Effective Date	07/17/2024
		Approval Date	07/17/2024
	Subject **Adcetris**	*Supersedes Date*	N/A
		Page	1 of 4

This document applies to the following Participating Organizations:

US Family Health Plan

Keywords: Adcetris

Table of Contents		Page Number
I.	**POLICY**	**1**
II.	**POLICY CRITERIA**	**1**
III.	**AUTHORIZATION PERIOD/LIMITATIONS**	**3**
IV.	**EXCLUSIONS**	**3**
V.	**RECOMMENDED DOSE**	**3**
VI.	**CODES**	**3**
VII.	**REFERENCES**	**3**
VIII.	**APPROVALS**	**3**

I. POLICY

A. Adcetris ((brentuximab vedotin) will require prior authorization for medical benefit coverage to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.

II. POLICY CRITERIA

A. Adcetris may be approved for patients who meet the following:

1. **Classical Hodgkin lymphoma (cHL)**
   a. Documentation has been submitted showing the patient has a diagnosis of CD30+ cHL, and Adcetris will be used in any of the following treatment scenarios:
      I. as monotherapy
      II. in combination with doxorubicin, vinblastine, and dacarbazine
      III. in combination with bendamustine for subsequent therapy
      IV. in combination with dacarbazine
      V. in combination with nivolumab for subsequent therapy
      VI. in combination with gemcitabine for subsequent therapy
      VII. in combination with ifosfamide, carboplatin and etoposide for subsequent therapy
      VIII. in combination with etoposide, prednisone and doxorubicin
      IX. in combination with cyclophosphamide, prednisone, and dacarbazine for subsequent therapy
      X. in combination with doxorubicin, vincristine, etoposide, prednisone and cyclophosphamide
2. **B-Cell Lymphomas**
   a. Documentation has been submitted showing the patient has a diagnosis of CD30+ B-cell lymphoma with any of the following subtypes:
      I. Monomorphic post-transplant lymphoproliferative disorders (B-cell type) when both of the following are met:
         i. Adcetris will be used for subsequent therapy
         ii. The patient is not a candidate for transplant
      II. Monomorphic post-transplant lymphoproliferative disorders (T-cell type) and Adcetris will be used in combination with cyclophosphamide, doxorubicin, and prednisone.

III. Diffuse large B-cell lymphoma when all of the following are met:
   i. Adcetris will be used as subsequent therapy
   ii. The patient is not a candidate for transplant
IV. HIV-Related B-cell lymphomas (HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma) when both of the following are met:
   i. Adcetris will be used for subsequent therapy
   ii. The patient is not a candidate for transplant
V. Pediatric primary mediastinal large B-cell lymphoma when both of the following are met:
   i. Adcetris will be used for relapsed or refractory disease
   ii. Adcetris will be used in combination with nivolumab or pembrolizumab
VI. High-grade B-cell lymphomas when both of the following are met:
   i. Adcetris will be used for subsequent therapy
   ii. The patient is not a candidate for transplant

3. **Primary Cutaneous Lymphomas**
   a. Documentation has been submitted showing the patient has a diagnosis of CD30+ primary cutaneous lymphomas with any of the following subtypes:
      I. Mycosis fungoides (MF)/Sezary syndrome (SS)
      II. Lymphomatoid papulosis (LyP) when both of the following are met:
         i. Adcetris will be used as a single agent
         ii. The disease is relapsed or refractory
      III. Cutaneous anaplastic large cell lymphoma when either of the following are met:
         i. Adcetris will be used as a single agent
         ii. Adcetris will be used in combination with cyclophosphamide, doxorubicin, and prednisone (CHP)
4. **T-Cell Lymphomas**
   a. Documentation has been submitted showing the patient has a diagnosis of CD30+ T-cell lymphomas with any of the following subtypes:
      I. Hepatosplenic T-cell lymphoma when either of the following are met:
         i. Adcetris will be used as a single agent after two or more primary treatment regimens
         ii. Adcetris will be used in combination with cyclophosphamide, doxorubicin, and prednisone
      II. Adult T-cell leukemia/lymphoma when either of the following are met:
         i. Adcetris will be used as a single agent for subsequent therapy
         ii. Adcetris will be used in combination with cyclophosphamide, doxorubicin, and prednisone
      III. Breast implant associated anaplastic large cell lymphoma (ALCL) when either of the following are met:
         i. Adcetris will be used as a single agent
         ii. Adcetris will be used in combination with cyclophosphamide, doxorubicin, and prednisone
      IV. Peripheral T-cell lymphoma (PTCL) [including the following subtypes: anaplastic large cell lymphoma, peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with TFH phenotype, or follicular T-cell lymphoma] when either of the following are met:
         i. Adcetris will be used a single agent for subsequent or palliative therapy
         ii. Adcetris will be used in combination with cyclophosphamide, doxorubicin, and prednisone
      V. Extranodal NK/T-cell lymphoma when all of the following are met:

i. Adcetris will be used as a single agent
ii. Patient has relapsed or refractory disease
iii. Patient has had an inadequate response or contraindication to asparaginase-based therapy (e.g., pegaspargase)

VI. Systemic anaplastic large cell lymphoma when either of the following are met:
i. Adcetris will be used as a single agent
ii. Adcetris will be used in combination with cyclophosphamide, doxorubicin, and prednisone (CHP)

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Initial approval will be limited to 12 months of therapy
B. Continuation of therapy may be approved in 12-month intervals with documentation showing the patient has not experienced unacceptable toxicity or disease progression while on treatment

IV. EXCLUSIONS

A. Adcetris will not be covered for the following:
1. Any indications or uses that are not FDA-approved, or guideline-supported

V. RECOMMENDED DOSE

Please refer to the FDA-approved prescribing information, or clinical guidelines, for indication-specific dosing details.

VI. CODES

Note: The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member's specific benefit plan determines coverage.

Medication	HCPCS/CPT Code
Injection, brentuximab vedotin, 1 mg	J9042

VII. REFERENCES

1. Adcetris [prescribing information]. Bothell, WA: Seagen Inc; November 2022.
2. The NCCN Drugs & Biologics Compendium® © 2023 National Comprehensive Cancer Network, Inc. Available at: https://www.nccn.org. Accessed July 9, 2024

VIII. APPROVALS

Signature on file at JHHP

DATE OF REVISION	SUMMARY OF CHANGE
07/17/2024	Policy creation

JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Pharmacy Public** **Medical Management Drug Policies**	*Policy Number*	MMDP102
		Effective Date	07/17/2024
		Approval Date	07/17/2024
	Subject **Adcetris**	*Supersedes Date*	N/A
		Page	4 of 4

Review Date: 07/17/2024

Revision Date: