SmartHealth Ascension

Mogamulizumab-kpkc (Poteligeo)

(Poteligeo®) J9204 (1mg)

Covered with prior authorization

Poteligeo® (Mogamulizumab-kpkc) may be authorized when the following criteria are met:

Poteligeo® (Mogamulizumab-kpkc) is being used for ONE of the following:

- Adult T-cell leukemia/lymphoma (ATLL), when used as a single-agent second line or subsequent therapy for acute or lymphoma subtypes; **OR**
- Mycosis fungoides (MF) or Sézary syndrome (SS).

Exclusion criteria:

- Product use for non-FDA approved indications or indications not supported by industry-accepted guidelines.
- Doses, durations, or dosing intervals that exceed FDA maximum limits for any FDA-approved indication or are not supported by industry-accepted practice guidelines or peer-reviewed literature for the relevant off-label use.

Initial authorization approval is up to 12 months.

Reauthorization approval is up to 12 months.

Reauthorization Criteria:
Poteligeo® (Mogamulizumab-kpkc) is considered medically necessary for continued use when initial criteria are met **AND** the patient has experienced clinical benefit to therapy **AND** has not experienced an unacceptable toxicity.

Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

U.S. Food and Drug Administration:
This section is to be used for informational purposes. FDA approval alone is not a basis for coverage.

Poteligeo® (Mogamulizumab-kpkc) is a CC chemokine receptor type 4 (CCR4)- directed monoclonal antibody indicated for the treatment of adult patients with relapsed or refractory mycosis fungoides or Sézary syndrome after at least one prior systemic therapy

References:

1. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm.
2. National Comprehensive Cancer Network. Cancer Guidelines and Drugs and Biologics Compendium. 2022.
3. Poteligeo [Prescribing Information]. Bedminister, NJ: Kyowa Kirin Inc; 2022.

Criteria History/ Revision Information:

Date	Summary of Changes
August 2022	Criteria for use summary developed by the Ascension Medical Specialty Prior Authorization Team.
September 2022	Criteria for use summary approved by the Ascension Ambulatory Care Expert Review Panel.
October 2022	Criteria for use summary approved by the Ascension Therapeutic Affinity Group.

If you have questions, call 833-980-2352 to speak to a member of the Ascension Rx prior authorization team, or email your questions to smarthealthspecialty@ascension.org.