Reference number(s)
2831-A

SPECIALTY GUIDELINE MANAGEMENT

ELZONRIS (tagraxofusp-erzs)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indication
Elzonris is a CD123-directed cytotoxin indicated for the treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN) in adults and in pediatric patients 2 years and older.

B. Compendial Use
Blastic plasmacytoid dendritic cell neoplasm (BPDCN)

All other indications are considered experimental/investigational and not medically necessary.

II. DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review: Medical record documentation that supports a confirmed diagnosis of BPDCN.

III. CRITERIA FOR INITIAL APPROVAL

Blastic plasmacytoid dendritic cell neoplasm (BPDCN)
Authorization of 12 months may be granted for treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN) when used as a single agent.

IV. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in Section III when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

V. REFERENCES

1. Elzonris [package insert]. New York, NY: Stemline Therapeutics, Inc.; July 2023.
2. The NCCN Drugs & Biologics Compendium® © 2024 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed January 6, 2024.