PROVIDER*ALERT*

AmeriHealth Caritas Louisiana

To: **AmeriHealth Caritas Louisiana Providers**

Date: **November 11, 2021**

Subject: **New Drug Policy Approvals**

Summary: New drug policies approved by the Louisiana Department of Health.

AmeriHealth Caritas Louisiana would like to make you aware of the attached policies that have been approved by the Louisiana Department of Health in accordance with La. R.S. 46:460.54 and **will become effective December 13, 2021.**

These drugs will no longer reimburse through retail pharmacy. Instead, claims will reimburse as provider-administered medications via medical benefits.

Missed an alert?
You can find a complete listing of provider alerts on the Provider Newsletters and Updates page of our website.

Where can I find more information on COVID-19?
AmeriHealth Caritas Louisiana has updated its website to streamline communications and important notifications about COVID-19. Please visit http://amerihealthcaritasla.com/covid-19 for up-to-date information for both providers and members, including frequently asked questions, and important provider alerts from AmeriHealth Caritas Louisiana and the Louisiana Department of Health.

Field Name	Field Description
Prior Authorization Group Description	Alpha-1 Proteinase Inhibitors (Human)
Drugs	Preferred: Prolastin-C Non-Preferred: Aralast NP Glassia Zemaira Or any other newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or specialist in the treatment of AAT
Coverage Duration	The request will be approved for up to a 12 month duration; if all of the above criteria are not met, the request is referred to a Medical Director for medical necessity review.
Other Criteria	**Drug is being requested through the member's medical benefit** Initial Authorization: • Documented diagnosis of a congenital deficiency of alpha-1 antitrypsin (AAT) (serum AAT level < 11 micromol/L or 80mg/dl). • Documentation was submitted indicating the member has undergone genetic testing for AAT deficiency and is classified as phenotype PiZZ, PiSZ, PiZ(null) or Pi(null)(null) [NOTE: phenotypes PiMZ or PiMS are not candidates for treatment with Alpha1-Proteinase Inhibitors] • Documentation was submitted (member's pulmonary function test results) indicating airflow obstruction by spirometry (forced expiratory volume in 1 second [FE_{V1}] in the range of 35%-65% of predicted), or provider has documented additional medical information demonstrating medical necessity • Documentation was submitted indicating member is a non-smoker or an ex-smoker (eg. smoking cessation treatment) • Documentation of the member's current weight

Revision/Review Date 6/2021	• **The Alpha-1 Proteinase Inhibitor (human) is being prescribed at an FDA approved dosage** • **If the medication request is for an Alpha1-Proteinase Inhibitor (human) product other than Prolastin-C, the patient has a documented medical reason (intolerance, hypersensitivity, contraindication, treatment failure, etc.) for not using Prolastin-C to treat their medical condition** **Reauthorization:** • **Documentation of the member's current weight** • **Documentation was submitted indicating the member has clinically benefited from therapy (i.e. stable lung function, improved PFTs, alpha-1 antitrypsin serum level maintained above 11 micromol/L or 80 mg/dL, improved quality of life)** • **The Alpha-1 Proteinase Inhibitor (human) is being prescribed at an FDA approved dosage** **Clinical reviewer/Medical Director must override criteria when, in his/her professional judgment, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Vascular Endothelial Growth Factor (VEGF) Inhibitors for Ophthalmic Conditions
Drugs	Preferred Vascular Endothelial Growth Factor (VEGF) Inhibitor(s): • Avastin, Mvasi, Zirabev (bevacizumab) • Lucentis (ranibizumab) Non-Preferred Vascular Endothelial Growth Factor (VEGF) Inhibitor(s): • Beovu (brolucizumab) • Eylea (afibercept) • Macugen (pegaptanib) • Any newly marketed agent in this class **If the request is for an alternative indication please use the Specialty Drugs Criteria or Oncology Drugs Criteria as appropriate**
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	Approvable for adults 18 years of age and older only
Prescriber Restrictions	Ophthalmologist
Coverage Duration	If the above conditions are met, the request will be approved with a 3 month duration for initial and 12 months for renewal; if the criteria are not met, the request will be referred to a clinical reviewer for medical necessity review.
Other Criteria	**Drug is being requested through the member's medical benefit** Avastin, Mvasi, Zirabev: • Request is for compendia supported dosing for an ophthalmic indication Lucentis: • Request is for an FDA-approved dosing regimen Non-Preferred VEGF Inhibitor: • Request is for an FDA-approved dosing regimen; AND

Revision/Review Date 5/2021	• **Documented trial and failure with a preferred VEGF inhibitor for all FDA-approved indications OR: a medical justification for not using a preferred VEGF inhibitor (e.g. experienced a severe ADR such as hypersensitivity, arterial thromboembolism, cerebrovascular accident, raised intraocular pressure, retinal detachment).** **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Primary Hemophagocytic Lymphohistiocytosis (HLH) Agents
Drugs	Gamifant (emapalumab-lzsg)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Members who have undergone hematopoietic stem cell transplantation (HSCT)
Required Medical Information	"See Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist, Immunologist, Transplant Specialist, or other specialist experienced in the treatment of immunologic disorders
Coverage Duration	Initial Authorization: 1 month Reauthorization: 3 months
Other Criteria	*Gamifant will only be approved for members who have not yet received HSCT and will be discontinued at the initiation of HSCT* **Drug is being requested through the member's medical benefit** Initial Authorization • Member has a diagnosis of Primary HLH • Member does NOT have a diagnosis of Secondary HLH due to a proven rheumatic or neoplastic disease or an infection • Prescriber attests that member has not achieved a satisfactory response to or is intolerant to conventional HLH therapy (e.g. etoposide, dexamethasone) or has recurrent disease • Prescriber attests that the member is a candidate for hematopoietic stem cell transplant (HSCT) • Member has been screened for latent tuberculosis infection • Member has or will receive prophylactic pre-medications (e.g. antivirals, antibiotics, antifungals) for Herpes Zoster, *Pneumocystis jirovecii*, and other fungal infections • Dosing is consistent with FDA approved labeling Reauthorization

Revision/Review Date 6/2021	• **Member continues to meet initial authorization criteria** • **Member is receiving prophylactic pre-medications (e.g. antivirals, antibiotics, antifungals) for Herpes Zoster, *Pneumocystis jirovecii*, and other fungal infections** • **HSCT has not yet been initiated for member** **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Insulin-Like Growth Factor-1 Receptor (Igf-1r) Antagonists For Thyroid Eye Disease
Drugs	Tepezza (teprotumumab-trbw)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be 18 years age or older
Prescriber Restrictions	Ophthalmologist
Coverage Duration	If all of the criteria are met, the request will be approved for up to 24 weeks of treatment (8 total infusions). Retreatment requests will not be allowed beyond the 8 dose limit.
Other Criteria	**Drug is being requested through the member's medical benefit** Initial Authorization: Tepezza is approved when all of the following are met: • Dosing does not exceed dosing guidelines as outlined in the package insert • Patient has a confirmed diagnosis of Graves' disease • Documentation of active moderate-severe thyroid eye disease as evidenced by one or more of the following: o Lid retraction of >2mm o Moderate or severe soft-tissue involvement o Proptosis ≥3mm above normal values for race and sex o Periodic or constant diplopia • Patients Clinical Activity Score must be ≥4 (must be submitted with request) • Patient must be euthyroid or thyroxine and free triiodothyronine levels are less than 50% above or below normal limits (submit laboratory results with request) • Patients of reproductive potential: attestation the patient is not pregnant, and appropriate contraception methods will be used before, during, and 6 months after the last

Revision/Review Date 6/2021	**infusion** • **Patient has had a trial and therapy failure of, or contraindication to, oral or IV glucocorticoids to treat their condition** **Re-authorization:** • **Retreatment or renewal requests beyond a total of 24 weeks of treatment (8 total infusions) will not be allowed.** **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Fabrazyme
Drugs	Fabrazyme (agalsidase beta)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	Members should be greater than or equal to 8 years of age
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, cardiologist, nephrologist or specialist experienced in the treatment of Fabry disease
Coverage Duration	Initial Authorization: If the criteria are met, the request will be approved for a 6-month duration. Reauthorization: If the criteria are met, the request will be approved for a 12-month duration.
Other Criteria	**Drug is being requested through the member's medical benefit** Initial Authorization: • Male members must have a documented diagnosis of Fabry disease confirmed by one of the following: 1. An undetectable (<3%) alpha galactosidase A (alpha-Gal-A) activity level OR 2. A deficient (3-35%) alpha-Gal- activity level AND a documented detection of pathogenic mutations in the galactosidase alpha (*GLA*) gene by molecular genetic testing • Female members must have a documented diagnosis of Fabry disease confirmed by detection of pathogenic mutations in the *GLA* gene by molecular genetic testing • Member must not be using concurrently with Galafold (migalastat) • Documentation of the member's current weight • Request is for an FDA-approved dose Re-Authorization:

Revision/Review Date: 6/2021	• **Documentation that member has experienced an improvement in symptoms from baseline including but not limited to: decreased pain, decreased gastrointestinal manifestations, decrease in proteinuria, stabilization of increase in eGFR, reduction of left ventricular hypertrophy (LVH) on echocardiogram, or improved myocardial function, or has remained asymptomatic** • **Member must not be using concurrently with Galafold (migalastat)** • **Documentation of the member's current weight** • **Request is for an FDA-approved dose** **If the criteria are not met, the request will be referred to a clinical reviewer for medical necessity review.** **Physician/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Dendritic Cell Tumor Peptide Immunotherapy
Drugs	Provenge (sipuleucel-T)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Small cell/neuroendocrine prostate cancer
Required Medical Information	See "Other Criteria"
Age Restrictions	See "Other Criteria"
Prescriber Restrictions	Prescriber must be an oncologist or urologist
Coverage Duration	3 doses per lifetime
Other Criteria Revision/Review Date 6/2021	**Drug is being requested through the member's medical benefit** Initial Authorization: • Metastatic castrate resistant (hormone-refractory) prostate cancer (mCRPC) (consistent with medical chart history) o Evidenced by soft tissue and/or bony metastases o Patient does NOT have ▪ M0CRPC (defined as CRPC whose only evidence of disseminated disease is an elevated serum PSA) is not authorized ▪ Visceral metastases (e.g. liver, lung, adrenal, peritoneal, brain) • Patient is not currently being treated with systemic immunosuppressants (e.g. chemotherapy, corticosteroids) or, if the patient is being treated with immunosuppressants, the prescriber has provided a valid medical reason for combination therapy • Eastern Cooperative Oncology Group (ECOG) score 0-1 • Serum testosterone <50 ng/dL (e.g. castration levels of testosterone) • Predicted survival of at least six months Reauthorization: • Treatment exceeding 3 doses per lifetime will not be authorized

	<u>Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.</u>

Field Name	Field Description
Prior Authorization Group Description	Complement Inhibitors
Drugs	Soliris (eculizumab), Ultomiris (ravulizumab)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, the Drug Package Insert, and/or per the standard of care guidelines
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, nephrologist, neurologist, oncologist, or other appropriate specialist.
Coverage Duration	If the criteria are met, the initial request will be approved for up to 3 month duration; reauthorization requests will be approved for up to 6 months. If the criteria are not met, the request will be referred to a clinical reviewer for medical necessity review.
Other Criteria	**Drug is being requested through the member's medical benefit** Initial Authorization: • The patient has a confirmed diagnosis that is indicated in the FDA approved package insert OR is a medically-accepted indication; AND • The request is age appropriate according to FDA approved package labeling or nationally recognized compendia; AND • The request is for a dose that is FDA approved or in nationally recognized compendia in accordance with the patient's diagnosis, age and concomitant medical conditions; AND • Documentation of vaccination against meningococcal disease or a documented medical reason why the patient cannot receive vaccination or vaccination needs to be delayed; AND • Antimicrobial prophylaxis with oral antibiotics for two weeks will be administered if vaccine is administered less than two weeks before starting Soliris/Ultomiris therapy or a documented medical reason why the patient cannot receive oral antibiotic prophylaxis. Generalized Myasthenia Gravis (gMG):

Revision/Review Date 6/2021	• **The request is for Soliris (eculizumab)**
	  o **If the request is for Ultomiris (ravulizumab), do not approve, not indicated for gMG**
	• **Patient has a positive serologic test for anti-AChR antibodies; AND**
	• **Patient has a Myasthenia Gravis Foundation of America (MGFA) clinical classification of class II,III or IV at initiation of therapy; AND**
	• **Patient has a Myasthenia Gravis-specific Activities of Daily Living scale (MG-ADL) total score ≥ 6 at initiation of therapy; AND**
	• **One of the following:**
	  o **Failed treatment over a total of 1 year or more with 2 or more immunosuppressive therapies (ISTs) either in combination or as monotherapy; OR**
	  o **Failed at least 1 IST and required chronic plasmapheresis or plasma exchange or intravenous immunoglobulin; OR**
	  o **Has a documented history of contraindications or intolerance to ISTs**
	
	Neuromyelitis Optica Spectrum Disorder (NMOSD)
	• **If the request is for Soliris (eculizumab)**
	  o **Refer to the "Neuromyelitis Optica Spectrum Disorder (NMOSD) Agents" policy**
	• **If the request is for Ultomiris (ravulizumab), do not approve; not indicated for NMOSD**
	
	Atypical Hemolytic Uremic Syndrome (aHUS)/Complement-Mediated HUS)
	• **Documentation of confirmed diagnosis as evidenced by complement genotyping and complement antibodies; OR**
	• **Provider attestation treatment is being used empirically and delay in therapy will lead to unacceptable risk to the patient**
	
	Re-Authorization:
	• **Provider has submitted documentation of clinical response to therapy (e.g., reduction in disease severity, improvement in quality of life scores, reduced need for blood transfusions); AND**
	• **The request is for an FDA approved dose; AND**
	• **If the request is for aHUS/Complement Mediated HUS**

	o **Documentation of confirmed diagnosis as evidenced by complement genotyping and complement antibodies** **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Brineura (cerliponase alfa)
Drugs	Brineura (cerliponase alfa)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert, and/or per the National Comprehensive Cancer Network (NCCN)
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	Member must be 3 years of age or older
Prescriber Restrictions	Prescriber must be a neurologist
Coverage Duration	If the criteria are met, the request will be approved for 6 months.
Other Criteria Revision/Review Date: 6/2021	**Drug is being requested through the member's medical benefit** Initial Authorization: • Documentation of confirmed diagnosis of late infantile neuronal ceroid lipofuscinosis type 2 (CLN2) with one of the following: o Lab results demonstrating deficient TPP1 enzyme activity o Identification of causative mutations in the TPP1/CLN2 gene • Prescribed dose is consistent with FDA-approved labeling • Documentation of baseline CLN2 Clinical Rating Scale motor +language score. Baseline CLN2 score must be > 0. Re-authorization: • Prescribed dose is consistent with FDA-approved labeling • Documentation of CLN2 Clinical Rating Scale motor +language score has remained > 0 Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Field Name	Field Description
Prior Authorization Group Description	Blincyto
Drugs	Blincyto (blinatumomab)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restriction	N/A
Prescriber Restrictions	Prescriber must be an oncologist/hematologist
Coverage Duration	The request will be approved for up to a 12 month duration; if all of the above criteria are not met, the request is referred to a Medical Director for medical necessity review.
Other Criteria Revision/Review Date 6/2021	**Drug is being requested through the member's medical benefit** Initial Authorization: • Patient has a diagnosis of one of the following forms of Acute Lymphoblastic Leukemia (ALL): a) Relapsed B-cell precursor ALL b) Refractory B-cell precursor ALL c) B-cell precursor ALL in first or second complete remission with minimal residual disease (MRD) greater than or equal to 0.1 • Provider attests to monitor patient for Cytokine Release Syndrome (CRS) and neurological toxicities Reauthorization: • Patient has a diagnosis of relapsed or refractory B-cell precursor ALL and has not exceeded 9 total cycles of Blincyto therapy • Provider attests to treatment response or stabilization of disease • Prescriber attests to monitor patient for Cytokine Release Syndrome (CRS) and neurological toxicities ***For B-cell precursor ALL with MRD, reauthorization is not allowed*** Medical Director/clinical reviewer must override criteria when,

	in his/her professional judgement, the requested item is medically necessary.

Field Name	Field Description
Prior Authorization Group Description	Anti-CD19 CAR-T Immunotherapies
Drugs	Kymriah (tisagenlecleucel), Yescarta (axicabtagene ciloleucel), Tecartus (brexucabtagene autoleucel), Breyanzi (lisocabtagene maraleucel)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Patients with primary central nervous system lymphoma
Required Medical Information	See "Other Criteria"
Age Restrictions	See "Other Criteria"
Prescriber Restrictions	Prescriber must be an oncologist, hematologist or other prescribers who specialize in the treatment of lymphoma.
Coverage Duration	If all the criteria are met, the initial request will be approved for a one – time infusion per lifetime.
Other Criteria	**Drug is being requested through the member's medical benefit** Initial authorization: • Patient must not have received prior anti-CD19 CAR-T therapy. • Patient will be screened for HBV, HCV, and HIV in accordance with clinical guidelines. • Patient does not have an active infection or inflammatory disorder. • Patient has a life expectancy >12 weeks. • Patient will not receive live virus vaccines for at least 6 weeks prior to the start of lymphodepleting chemotherapy and until immune recovery following treatment. Leukemia B-cell precursor Acute Lymphoblastic Leukemia (ALL): • If the request is for Kymriah o Patient is 25 years of age or younger o ALL that is refractory or in second or later relapse Non-Hodgkin's Lymphoma (NHL)

Revision/Review Date: 6/2021	**Mantle Cell Lymphoma (MCL):** • **If the request is for Tecartus:** o **Patient is 18 years of age or older** o **Patient has relapsed/refractory disease defined as failure of BOTH the following lines of therapy:** ▪ **Chemoimmunotherapy such as an anti-CD20 monoclonal antibody (e.g. Rituxan) + any chemotherapeutic agent** ▪ **Bruton Tyrosine Kinase (BTK) Inhibitor (e.g. Calquence, Imbruvica, Brukinsa)** **Other forms of NHL:** • **If the request is for Breyanzi (lisocabtagene maraleucel), Kymriah (tisagenlecleucel), Yescarta (axicabtagene ciloleucel)** o **Use is supported by a labeled indication or NCCN guidelines** o **Patient is 18 years of age or older** o **Patient has relapsed/refractory disease defined as failure of two or more lines of systemic therapy** **Re-authorization:** • **Treatment exceeding 1 dose per lifetime will not be authorized.** **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	B-Cell Maturation Antigen (BCMA) Directed Chimeric Antigen Receptor (CAR) T-Cell Therapy
Drugs	Abecma (idecabtagene vicleucel)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be 18 years or older
Prescriber Restrictions	Prescriber must be a hematologist, an oncologist, or other appropriate specialist
Coverage Duration	If all the criteria are met, the initial request will be approved for a one – time infusion per lifetime.
Other Criteria Revision/Review Date 6/2021	**Drug is being requested through the member's medical benefit** Initial Authorization • Member has a diagnosis of relapsed or refractory multiple myeloma (RRMM) • Member must have received at least 4 prior lines of therapy, which must include ALL of the following: o An immunomodulatory agent (e.g. lenalidomide, pomalidomide, thalidomide) o A proteasome inhibitor (e.g. bortezomib, carfilzomib, ixazomib) o An anti-CD38 monoclonal antibody (e.g. daratumumab, isatuximab) • Member does not have an active infection • Member will be screened for cytomegalovirus (CMV), hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV) in accordance with clinical guidelines • Member will not receive live virus vaccines for at least 6 weeks prior to the start of lymphodepleting chemotherapy and until immune recovery following treatment Re-authorization: • Treatment exceeding 1 dose per lifetime will not be authorized. Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.