P&T Committee Meeting Minutes
Medicaid
May 12, 2026

Present (via Teams):	**Absent:**
Bret Yarczower, MD, MBA – Chair	Alyssa Cilia, RPh
Amir Antonious, Pharm.D.	Bhargavi Degapudi, MD
Leslie Astleford, Pharm.D.	Michael Dubartell, MD
Emily Bednarz, Pharm.D.	Michael Evans, RPh
Kristen Bender, Pharm.D.	Nichole Hossler, MD
Jeremy Bennett, MD	Emily Jacobson, Pharm.D.
Angela Bolesta, Pharm.D.	Kerry Ann Kilkenny, MD
Kim Castelnovo, RPh	Philip Krebs, R.EEG T
Kimberly Clark, Pharm.D.	Lauren Lesh, Pharm.D.
Keri Donaldson, MD, MSCE	Perry Meadows, MD
Kelly Faust, Pharm.D.	Jonas Pearson, RPh
Tricia Heitzman, Pharm.D.	Angela Scarantino
Jason Howay, Pharm.D.	Kirsten Smith, Pharm.D.
Keith Hunsicker, Pharm.D.	Jill Stone, Pharm.D.
Kelli Hunsicker, Pharm.D.	Luke Sullivan, DO
Dennis Janosczyk, Pharm.D.	Amanda Taylor, MD
Alexandra Kempf-Malys, MSW, BSc	
Briana LeBeau, Pharm.D.	
Lisa Manoski, Pharm.D.	
Ted Marines, Pharm.D.	
Lisa Mazonkey, RPh	
Tyreese McCrea, Pharm.D.	
Jamie Miller, RPh	
Mark Mowery, Pharm.D.	
Andrei Nemoianu, MD	
Kara Pabst, Pharm.D.	
Austin Paisley, Pharm.D.	
Kimberly Reichard, Pharm.D.	
Melissa Sartori, Pharm.D.	
Kristen Scheib, Pharm.D.	
Michael Shepherd, MD	
Aubrielle Smith-Masri, Pharm.D.	
Michael Spishock, RPh	
Todd Sponenberg, Pharm.D.	
Kevin Szczecina, RPh	
Ariana Wendoloski, Pharm.D.	
Brandon Whiteash, Pharm.D.	

Margaret Whiteash, Pharm.D. Abigail Chua, DO (non-voting participant) Jeremy Garris, Pharm.D. (non-voting participant)	

Call to Order: Dr. Bret Yarczower called the meeting to order at 1:03 p.m., Tuesday May 12, 2026.

Review and Approval of Minutes, Reviews, Fast Facts, and Updates: The March 10, 2026 minutes will be presented during the June P&T.

DRUG REVIEWS

Voyxact (sibeprenlimab-szsi)

Review: Voyxact is indicated to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk for disease progression. This is an accelerated approval based on reduction of proteinuria. It has not been established whether Voyxact slows kidney decline long-term in patients with IgAN. Voyxact is the first inhibitor of A Proliferation Inducing Ligand (APRIL) which results in reduced level of serum galactose-deficient immunoglobulin A1 (Gd-IgA1) which is implicated in the pathogenesis of IgAN.

Clinical Discussion: The committee unanimously voted to accept the recommendations.

Financial Discussion: The committee unanimously voted to accept the recommendations.

Outcome: Voyxact is a pharmacy benefit that will be managed by GHP. It should not be added to the GHP Family formulary. The following prior authorization criteria should apply:

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of primary immunoglobulin A nephropathy (IgAN) verified by biopsy **AND**
- Medical record documentation that Voyxact is prescribed by or in consultation with a nephrologist **AND**
- Medical record documentation that patient is at risk of disease progression, defined as proteinuria greater than 1 gram/day **AND**
- Medical record documentation of estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min/1.73 m2 **AND**
- Medical record documentation that member has received a stable dose of a renin-angiotensin system (RAS) Inhibitor (ACE inhibitor or ARB) at a maximally tolerated dose for greater than or equal to 90 days **AND**
- Medical record documentation that member has received greater than or equal to 90 days of optimized supportive care, including blood pressure management, lifestyle modification, and cardiovascular risk modification **AND**
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

Formulary Alternatives: Filspari (requires prior authorization)

Authorization Duration: Initial approval will be for 9 months. Subsequent authorizations will be for 12 months and will require:

- Medical record documentation of continued disease improvement or lack of disease progression according to prescriber (i.e., decreased levels of proteinuria from baseline or decreased urine protein-to-creatinine ratio (UPCR) from baseline)

Quantity Limit: 28-day supply per fill
GPI Level: GPI-12

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Ryoncil (remestemcel-L-rknd)

Review: Ryoncil is indicated for the treatment of steroid-refractory acute graft versus host disease (SR-aGvHD) in pediatric patients 2 months of age and older. Ryoncil is comprised of culture-expanded mesenchymal stromal cells (MSCs) isolated from bone marrow of healthy humans and donors. The mechanism of action in the treatment of SR-aGvHD is unclear but may be related to immunomodulatory effects of MSCs which inhibit T cell activation and secretion of pro-inflammatory cytokines. Alloreactive donor-derived T cells in acute GvHD may trigger an immunological response and mediate systemic inflammation, cytotoxicity and potential end organ damage associated with aGVHD. Ryoncil is the first agent approved for SR-aGvHD in pediatric patients less than 12 years of age. Ryoncil will compete with Jakafi approved for SR-aGvHD in patients ≥ 12 years of age

Clinical Discussion: The committee unanimously voted to accept the recommendations.

Financial Discussion: The committee unanimously voted to accept the recommendations.

Outcome: Ryoncil will process as a medical benefit and will be managed by GHP The following prior authorization criteria should apply:

- Medical record documentation that Ryoncil is prescribed by a hematologist/oncologist or transplant specialist **AND**
- Medical record documentation of age greater than or equal to 2 months to less than 18 years **AND**
- Medical record documentation of a diagnosis of steroid refractory graft-versus-host disease (GVHD)

Authorization Duration: Initial approval will be for 2 months or less if the reviewing provider feels it is medically appropriate. One subsequent approval will be for an additional 1 month or less if the reviewing provider feels it is medically appropriate and will require documentation of the following:

- Medical record documentation of a complete response following initial treatment with Ryoncil AND documentation of recurrent steroid refractory graft-versus-host disease (GVHD)

Quantity Limit:
Initial Authorization: 2-month duration with a quantity limit of 12 doses
Reauthorization: 1-month duration with a quantity limit of 8 doses

Require RPH Sign off: Yes.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Zevaskyn (prademagene zamikeracel)

Review: Zevaskyn is indicated for the treatment of wounds in adult and pediatric patients with recessive dystrophic epidermolysis bullosa (RDEB). It is a gene therapy comprised of a patient's own cells genetically modified to express COL7A1 gene to produce C7 protein, which forms anchoring fibrils (AFS). In RDEB, both copies of the COL7A1 gene are mutated, resulting in low or absent levels of C7 protein and decreased formation of Afs. The lack of Afs disrupts the connection between the epidermis and dermis causing skin fragility and other symptoms of RDEB.

Clinical Discussion: The committee unanimously voted to accept the recommendations.

Financial Discussion: The committee unanimously voted to accept the recommendations.

Outcome: Zevaskyn is a medical benefit that will be managed by GHP. The following prior authorization criteria should apply:

- Medical record documentation that Zevaskyn is prescribed by or in consultation with a dermatologist or wound care specialist who specializes in epidermolysis bullosa (EB) management AND
- Medical record documentation of age greater than or equal to 6 years AND
- Medical record documentation of diagnosis of recessive dystrophic epidermolysis bullosa (RDEB) AND
- Medical record documentation of at least one clinical feature of RDEB (recessive dystrophic epidermolysis bullosa) including but not limited to blistering, scarring and skin wounds AND
- Medical record documentation of genetic testing confirming mutation(s) in both alleles in the collagen type VII alpha 1 chain (COL7A1) gene AND
- Medical record documentation of at least one open dystrophic epidermolysis bullosa (DEB) wound AND all of the following:
    - documentation of the presence of partial-thickness RDEB wounds open chronically for greater than or equal to 6 months AND
    - documentation that member does not have current evidence or a history of squamous cell carcinoma (SCC) in the wound area AND
    - documentation that the wound area has not been previously treated with Zevaskyn

- Medical record documentation that member does not have an immune response to C7 by indirect immunofluorescence (IIF)

AND

- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature AND
- Medical record documentation that Zevaskyn will not be used concomitantly with another treatment indicated for dystrophic epidermolysis bullosa (DEB) (i.e. Vyjuvek, Filsuvez

Auth Duration: Approve for three months auth duration for one application of up to 12 gene-modified cellular sheet

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Kresladi (marnetegragene autotemcel)

Review: Kresladi is an autologous stem cell-based gene therapy indicated for the treatment of pediatric patients with severe leukocyte adhesion deficiency-I (LAD-I) due to biallelic variants in *ITGB2* without an available human leukocyte antigen (HLA)-matched sibling donor for allogenic hematopoietic stem cell transplant. This indication is approved under accelerated approval based on increase in neutrophil CD18 and CD11a surface expression as reported in clinical trial NCT03812263. Continued approval may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

Clinical Discussion: The committee unanimously voted to accept the recommendations.

Financial Discussion: The committee unanimously voted to accept the recommendations.

Outcome: Kresladi will be a medical benefit managed by GHP. The following prior authorization criteria will apply:

- Medical record documentation of an age greater than or equal to 3 months and less than 18 years of age AND
- Medical record documentation that Kresladi is being prescribed by or in consultation with an immunologist, hematologist, oncologist, infectious disease specialist, or other providers with expertise in the diagnosis and treatment of leukocyte adhesion deficiency-I (LAD-I) AND
- Medical record documentation of a confirmed diagnosis of severe LAD-I demonstrated by **ONE** of the following:
    - Flow cytometry indicating CD18 expression on < 2% neutrophils (polymorphonuclear neutrophils [PMNs]) OR
    - For patients in which CD18+ PMNs are > 2%, one of the following:
        - <2% CD11a or CD11b expressing PMNs AND
        - Documented *ITGB2* mutation AND

    - Clinical history consistent with LAD-I **OR** documented known family history of LAD-I
- Medical record documentation that the patient is considered to be an appropriate candidate for autologous transplantation of hematopoietic stem cells AND
- Medical record documentation that the patient is **NOT** pregnant or breastfeeding AND
- Medical record documentation that the patient does **NOT** have a medically-eligible human leukocyte antigen (HLA)-matched sibling stem cell donor **OR** a feasible HLA-matched sibling donor for stem cell collection is not identified (e.g., donor is in utero, is a newborn from whom cord blood was not collected, or is unable to undergo donation procedure because of medical impairments) AND
- Medical record documentation that the patient does **NOT** have hepatic dysfunction as defined by bilirubin > 1.5 x the upper limit of normal OR alanine aminotransferase (ALT) or aspartate aminotransferase (AST) > 2.5 x the upper limit of normal AND
- Medical record documentation that the patient does **NOT** have renal dysfunction or the requirement for either peritoneal dialysis or hemodialysis AND
- Medical record documentation that the patient does **NOT** have pulmonary dysfunction as defined by either the need for supplemental oxygen during the prior 2 weeks (in absence of acute infection) **OR** oxygen saturation (by pulse oximetry) < 90% AND
- Medical record documentation that the patient does **NOT** have a serious, untreated infection with persistent bloodstream pathogens AND
- Medical record documentation that the patient does **NOT** have active or metastatic locoregionally advanced malignancy (including hematologic malignancy) for which survival is anticipated to be less than 3 years AND
- Medical record documentation that the patient does **NOT** have significant medical conditions including documented human immunodeficiency virus (HIV) infection, poorly controlled diabetes, poorly controlled hypertension, poorly controlled cardiac arrhythmia or heart failure, or arterial thromboembolic events (including myocardial infarction or stroke) within the prior 6 months AND
- Medical record documentation that the patient has **NOT** received prior treatment with Kresladi

AUTHORIZATION DURATION: One (1) time approval (auth duration: 3 months) per lifetime. Requests for authorizations exceeding these limits will require the following medical record documentation of peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee

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NexoBrid (anacaulase-bcdb)

Review: Nexobrid is a topical enzymatic debridement agent containing proteolytic enzymes enriched in bromelain from pineapple stems for selective eschar removal in deep partial-thickness (DPT) and full-thickness (FT) thermal burns.

Clinical Discussion: The committee unanimously voted to accept the recommendations.

Financial Discussion: The committee unanimously voted to accept the recommendations.

Outcome: *NexoBrid* is a Medical Benefit that will not be covered as its manufacturer, Vericel, is a non-rebateable manufacturer. If the manufacturer becomes rebateable, NexoBrid will be managed by the PDL.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

FASTFACTS

Tevimbra

Updated Indication: Tevimbra is now approved for use in combination with platinum-containing chemotherapy for the first-line treatment of adults with unresectable or metastatic esophageal squamous cell carcinoma (ESCC) whose tumors express PD-L1 ≥ 1

Discussion: The committee unanimously voted to accept the recommendations.

Outcome: There are no changes recommended for the formulary placement or authorization duration of Tevimbra. The following changes are recommended to MBP 331 (highlighted yellow).

Esophageal Squamous Cell Carcinoma (ESCC)

- Medical record documentation of age greater than or equal to 18 years AND
- Medical record documentation that Tevimbra is prescribed by a hematologist or oncologist **AND**
- Medical record documentation of a diagnosis of unresectable or metastatic esophageal squamous cell carcinoma (ESCC) **AND**
- Medical record documentation of disease progression after one or more prior lines of systemic chemotherapy that did not include a PD-(L)1 inhibitor

OR

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that Tevimbra is prescribed by a hematologist or oncologist **AND**
- Medical record documentation of a diagnosis of unresectable or metastatic esophageal squamous cell carcinoma (ESCC) **AND**
- Medical record documentation that Tevimbra will be used in combination with platinum-containing chemotherapy for first-line treatment **AND**
- Medical record documentation that the tumors express PD-L1 (≥1)

Gastric Cancer

- Medical record documentation of age greater than or equal to 18 years AND
- Medical record documentation that Tevimbra is prescribed by a hematologist or oncologist **AND**
- Medical record documentation of unresectable or metastatic HER2- negative gastric or gastroesophageal junction adenocarcinoma whose tumors express PD-L1 (≥1) **AND**

- Medical record documentation that Tevimbra will be used with platinum and fluoropyrimidine-based chemotherapy for first line treatment

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

UPDATES

Tepezza

Recommendation According to guidelines and UpToDate, Tepezza is the preferred product in patients with active moderate-to-severe TED with significant proptosis and/or diplopia.).

Discussion: The committee unanimously voted to accept the recommendation.

Outcome: It is recommended to update the criteria for MBP 217.0 Tepezza (teprotumumab-trbw).

- Prescription written by an ophthalmologist **AND**
- Medical record documentation of the member being ≥ 18 years of age **AND**
- Medical record documentation of a diagnosis of Grave's disease **AND**
- Medical record documentation of moderate to severe Thyroid Eye Disease with documentation of one or more of the following: lid retraction of ≥ 2mm, moderate or severe soft-tissue involvement, proptosis ≥ 3 mm above normal values for race and sex, or periodic or constant diplopia **AND**
- Medical record documentation that the member is euthyroid or has mild hypo- or hyperthyroidism (free T4 and free T3 levels <50% above or below normal limits) prior to starting Tepezza therapy OR patient has been initiatedlo on anti-thyroid medication **AND**
- Medical record documentation that the member is being prescribed an appropriate dose and duration of Tepezza (10 mg/kg as a single dose, followed by 20 mg/kg IV every 3 weeks for 7 additional doses) **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to systemic steroids OR evidence of significant proptosis (≥ 3 mm above normal values for race and sex) and/or diplopia.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee

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New Oncology Formulations

Recommendation The following updates should be made

Rybrevant Faspro, Lunsumio Velo: Medical Benefit Drug, PA required
Jobevne: Medical Benefit Drug, No PA required
Zusduri: Medical Benefit Drug, PA required
Kyxata – Medical Benefit Drug, PA required

- Medical record documentation of therapeutic failure, intolerance, or contraindication to generic carboplatin products

Ivra – Medical Benefit Drug, PA required

- Medical record documentation of therapeutic failure, intolerance, or contraindication to generic melphalan products

Pemrydi RTU – Medical Benefit Drug, PA required

- Medical record documentation of therapeutic failure, intolerance, or contraindication to generic pemetrexed products

Boruzu – Medical Benefit Drug, PA required

- Medical record documentation of therapeutic failure, intolerance, or contraindication to generic bortezomib products

Discussion: The committee unanimously voted to accept the recommendation.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee

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DUR Update

The May 2026 Medicaid DUR/Adherence Update was submitted to the Committee for review

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee

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April ELECTRONIC VOTE
An electronic vote was held from April 3, 2026, to April 11, 2026. Responses were received from 31 members (out of 49 members) and all voted to approve. Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Recarbrio

Updated Indication: Recarbrio is now indicated for adults and pediatric patients weighing at least 2 kg for the treatment of the following infections caused by susceptible gram-negative microorganisms: hospital-acquired bacterial pneumonia and ventilator-associated bacterial pneumonia (HABP/VABP), complicated urinary tract infections, including pyelonephritis (cUTI) in patients who have limited or no alternative treatment options, and complicated intra-abdominal infections (cIAI) in patients who have limited or no alternative treatment options. Previously Recarbrio was only indicated for the treatment of adult patients. Recarbrio is not recommended in pediatric patients less than 37 weeks post-menstrual age (gestational age at birth plus post-natal age) or in pediatric patients weighing less than 30 kg with renal impairment.

Recommendation: No changes are needed to the formulary placement, authorization duration, or quantity limits for Recarbrio. It is recommended that the Medical Benefit Policy be updated to remove the age criterion.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Tecvayli

Updated Indication: Tecvayli is now indicated for the treatment of adult patients with relapsed or refractory multiple myeloma in combination with daratumumab hyaluronidase-fihj in patients who have received at least one prior line of therapy, including a proteasome inhibitor and an immunomodulatory agent.

Recommendation: There are no changes recommended to the formulary placement or authorization duration. The following changes are recommended for Medical Benefit Policy 273.0 to incorporate the new indication.

- Medical record documentation that Tecvayli is prescribed by a hematologist or oncologist **AND**
- Medical record documentation of age greater than or equal to 18 years old **AND**
- Medical record documentation of a diagnosis of relapsed or refractory multiple myeloma **AND**
- Medical Record documentation of one of the following:
    - Medical record documentation that Tecvayli is being used as monotherapy AND documentation of treatment with at least four (4) prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent and an anti-CD38 monoclonal antibody OR
    - Medical record documentation that Tecvayli is being used in combination with daratumumab hyaluronidase-fihj (Darzalex Faspro) AND documentation of treatment with at least one prior line of therapy, including a proteasome inhibitor and an immunomodulatory agent

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Uplizna

Updated Indication: Uplizna has recently been approved for two additional indications in addition to neuromyelitis optica spectrum disorder (NMOSD). The new indications are:

- Immunoglobulin G4-related disease (IgG4-RD) in adult patients
- Generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) or anti-muscle specific tyrosine kinase (MuSK) antibody positive

Recommendation: Prior authorization criteria for Immunoglobulin G4-related disease and generalized myasthenia gravis will be added to MBP 225 Uplizna. The new criteria are listed below.

For Immunoglobulin G4-Related Disease (IgG4-RD)

- Medical record documentation of age 18 years or older AND
- Medical record documentation that Uplizna is prescribed by or in consultation with a rheumatologist, hepatologist, immunologist, endocrinologist, nephrologist, or other provider with experience in treating IgG4-RD AND
- Medical record documentation of a confirmed diagnosis of IgG4-RD based on the American College of Rheumatology/European League Against Rheumatism (ACR/EULAR) classification criteria AND
- Medical record documentation of involvement of at least 1 or more organ (e.g., pancreas, kidneys, orbital structures, salivary glands, and retroperitoneum) in a manner consistent with IgG4-RD AND
- Medical record documentation that the patient is refractory to or has a contraindication for the use of glucocorticoids AND
- Medical record documentation that Uplizna will not be used in combination with a disease modifying therapy for the treatment of IgG4-RD (e.g., rituximab)

For Generalized Myasthenia Gravis

- Medical record documentation of age 18 years or older AND
- Medical record documentation that Uplizna is prescribed by or in consultation with a neurologist AND
- Medical record documentation of a diagnosis of generalized myasthenia gravis (gMG) that is anti-acetylcholine receptor (AChR) positive OR anti-muscle-specific tyrosine kinase (MuSK) antibody positive AND

- Medical record documentation of Myasthenia Gravis Foundation of America Clinical Classification (MGFA) Class II to IVa AND
- Medical record documentation of a baseline Myasthenia Gravis-Activities of Daily Living (MG-ADL) score greater than or equal to 6 AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to corticosteroids AND
- Medical record documentation of therapeutic failure on intolerance to, or contraindication to at least two (2) non-steroidal immunosuppressive therapies OR has failed at least one (1) immunosuppressive therapy and required chronic plasmapheresis or plasma exchange (PE) AND
- Medical record documentation of failure on, intolerance to, or contraindication to intravenous immunoglobulin (IVIG).

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the Committee

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Medical Benefit Policy Update

Yescarta Update

Discussion: The prescribing information for Yescarta was updated on February 2026 to remove the limitation of use for Primary Central Nervous System Lymphoma (PCNSL). An approval letter by the FDA was drafted on February 5, 2026 outlining the change. The neurologic toxicities warning and precaution was updated to include results for Study 4, a single-arm, single-center, open-label study in 13 patients with relapsed or refractory PCNSL. 11 of 13 patients (85%) had neurological toxicities, with 4 of 13 (31%) having grade 3 neurologic toxicities. The most common included confusional state (38%), headache (31%), somnolence (31%), disturbance in attention (23%), lethargy (23%), tremor (23%), gait disturbance (15%), hypersomnia (15%), insomnia (15%), and seizures (15%). Rates of neurologic toxicities from other trials of Yescarta in the prescribing information were 78%, 87% and 77%. Other common adverse reactions from Study 4 are listed within the prescribing information.

Recommendations: It is recommended to remove the note from MBP 162.0 stating that Yescarta is not indicated for treatment of patients with PCNSL.

MBP 162.0 Yescarta (axicabtagene ciloleucel)

Large B-Cell Lymphoma (second-line)

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation that patient is 18 years of age or older **AND**
- Medical record documentation of large B-cell lymphoma that is refractory to first-line chemoimmunotherapy OR that relapses within 12 months of first-line chemoimmunotherapy **AND**
- Medical record documentation that the member has not received prior treatment with CAR-T cell therapy or other genetically modified T cell therapy

Large B-Cell Lymphoma (third-line or beyond)

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation that patient is 18 years of age or older **AND**
- Medical record documentation of one of the following diagnoses:
    - Relapsed or refractory diffuse large B-cell lymphoma (DLBCL) not otherwise specified OR
    - Relapsed or refractory primary mediastinal large B-cell lymphoma OR
    - Relapsed or refractory high-grade B-cell lymphoma OR
    - Relapsed or refractory diffuse large B-cell lymphoma (DLBCL) arising from follicular lymphoma

AND

- Medical record documentation of a therapeutic failure on two or more previous lines of therapy **AND**
- Medical record documentation that the member has not received prior treatment with CAR-T cell therapy or other genetically modified T cell therapy

~~Note: Yescarta is not indicated for the treatment of patients with primary central nervous system lymphoma.~~

Meeting adjourned at 4:31 PM

Future Scheduled Meetings
The next bi-monthly scheduled meeting will be held July 14, 2026.

Meetings will be held virtually via phone/Microsoft Teams