

PA Criteria	Criteria Details						
<b>Covered Uses (FDA approved indication)</b>	Tecartus is a CD19-directed genetically modified autologous T cell immunotherapy indicated for the treatment of adult patients with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL).						
<b>Exclusion Criteria</b>	None.						
<b>Required Medical Information</b>	Medical records supporting the request must be provided.						
<b>Other Criteria</b>	Must follow NCD 110.24 for Chimeric Antigen Receptor (CAR) T-Cell Therapy. <a href="https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=374">https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=374</a>						
<b>Age Restriction</b>	None.						
<b>Prescriber Restrictions</b>	None.						
<b>Coverage Duration</b>	In accordance with the FDA-approved labeling or accepted standards of medical practice.						
<b>Other Criteria/Information</b>	Refer to the Gold Coast Health Plan Medicare Part B Reference and Summary of Evidence document. <table border="1" data-bbox="500 989 1511 1163"> <thead> <tr> <th>HCPCS</th> <th>Description</th> <th>Billing Units/How Supplied</th> </tr> </thead> <tbody> <tr> <td>Q2053</td> <td>Tecartus (brexucabtagene autoleucl)</td> <td><b>Billing unit: per dose</b>  Up to 2x10<sup>8</sup> CAR+ t cells per SD infusion bag</td> </tr> </tbody> </table>	HCPCS	Description	Billing Units/How Supplied	Q2053	Tecartus (brexucabtagene autoleucl)	<b>Billing unit: per dose</b>  Up to 2x10 <sup>8</sup> CAR+ t cells per SD infusion bag
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STATUS	DATE REVISED	REVIEW DATE	APPROVED/REVIEWED BY	EFFECTIVE DATE
Created	3/26/2025	3/26/2025	Dawn Shojai, PharmD, Senior Pharmacy Benefit Consultant (PSG)	N/A
Approved	N/A	5/15/2025	Pharmacy & Therapeutics (P&T) Committee	5/15/2025