

PA Criteria	Criteria Details						
Covered Uses (FDA approved indication)	Aucatzyl 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).						
Exclusion Criteria	None.						
Required Medical Information	Medical records supporting the request must be provided.						
Other Criteria	Must follow NCD Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24). https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=374						
Age Restriction	None.						
Prescriber Restrictions	None.						
Coverage Duration	In accordance with the FDA-approved labeling or accepted standards of medical practice.						
Other Criteria/Information	Refer to the Gold Coast Health Plan Medicare Part B Reference and Summary of Evidence document. <table border="1" data-bbox="500 993 1511 1171"> <thead> <tr> <th>HCPCS</th> <th>Description</th> <th>Billing Units/How Supplied</th> </tr> </thead> <tbody> <tr> <td>Q2058</td> <td>Obecabtagene autoleucl</td> <td>Billing unit: per dose 10 to up to 400 x 10⁶ CD19 CAR+ T cells, per infusion</td> </tr> </tbody> </table>	HCPCS	Description	Billing Units/How Supplied	Q2058	Obecabtagene autoleucl	Billing unit: per dose 10 to up to 400 x 10 ⁶ CD19 CAR+ T cells, per infusion
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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