Elzonris (tagraxofusp-erzs)

Override(s)	Approval Duration
Prior Authorization	1 year

Medications
Elzonris (tagraxofusp-erzs) injection

APPROVAL CRITERIA

Requests for Elzonris (tagraxofusp-erzs) may be approved if the following criteria are met:

I. Individual is 2 years of age or older; **AND**
II. Individual has a diagnosis of blastic plasmacytoid dendritic cell neoplasm (BPDCN); **AND**
III. Individual has a current Eastern Cooperative Oncology Group (ECOG) status of 0-1; **AND**
IV. Individual is using as monotherapy**; AND**
V. At initial therapy, individual has a baseline serum albumin of 3.2 g/dL or higher (NCCN 2A).

Requests for Elzonris (tagraxofusp-erzs) may not be approved when the above criteria are not met and for all other indications.

Key References:

1. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2021. URL: http://www.clinicalpharmacology.com. Updated periodically.
2. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed: January 8, 2021.
3. DrugPoints® System [electronic version]. Truven Health Analytics, Greenwood Village, CO. Updated periodically.
4. Elzonris [Package Insert]. New York, NY. Stemline Therapeutics, Inc.; 2018
5. Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2021; Updated periodically.
6. NCCN Clinical Practice Guidelines in Oncology™. © 2020 National Comprehensive Cancer Network, Inc. For additional information visit the NCCN website: http://www.nccn.org/index.asp. Accessed on January 8, 2021.
    a. Acute Myeloid Leukemia. V2.2021. Revised November 12, 2020.