

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.

Federal and state laws or requirements, contract language, and Plan utilization management programs or policies may take precedence over the application of this clinical criteria.

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