

**SOUTH DAKOTA MEDICAID
PRIOR AUTHORIZATION CRITERIA**

Physician Administered Drugs, Vaccines, and Immunizations

Lifileucel (Amtagvi) – PA Criteria

HCPC: J9999

Lifileucel (Amtagvi) is an autologous tumor infiltrating lymphocyte (TIL) cell immunotherapy indicated for the treatment of unresectable or metastatic melanoma. It is covered by South Dakota Medicaid following prior authorization when the patient meets the following criteria:

**** All requests under this policy require SD medical director review in addition to meeting specified criteria below ****

- **Initial Therapy (must meet all):**
 - Therapy is prescribed by an oncologist
 - Individual has a diagnosis of melanoma
 - Disease is classified as unresectable or metastatic and documentation is provided that the individual has failed a PD-1 blocking antibody and, if *BRAF* V600 mutation positive, a BRAF inhibitor with or without a MEK inhibitor
 - Individual is ≥18 years of age
 - Member has not received an organ allograft, Car-T or TIL therapy in the past and therapy will not be utilized in conjunction with Car-T therapies
 - Approval duration: one dose
- **Continuation of Therapy (must meet all):** not authorized