UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Valchlor

Program	Prior Authorization
Medication	Valchlor™ gel for topical use (mechlorethamine)
Markets in Scope	Arizona, California, Colorado, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania- CHIP, Rhode Island, South Carolina
Issue Date	3/2014
Pharmacy and Therapeutics Approval Date	9/2020
Effective Date	11/2020

1. Background:

Valchlor (mechlorethamine) is an alkylating drug indicated for the topical treatment of Stage IA and IB mycosis fungoides-type cutaneous T-cell lymphoma in patients who have received prior skin-directed therapy.[1] The National Cancer Comprehensive Network (NCCN) recommends use of topical mechlorethamine in T-cell leukemia/lymphoma, primary cutaneous B-cell lymphoma and primary cutaneous CD30+ T-cell lymphoproliferative disorders.[2]

2. Coverage Criteria:

A. Primary Cutaneous Lymphomas

1. Initial Authorization

a. **Valchlor** will be approved based on the following criteria:

(1) Diagnosis of **one** of the following:

(a) Chronic or smoldering T-cell leukemia/lymphoma
(b) Primary cutaneous marginal zone or follicle center B-cell lymphoma
(c) Lymphomatoid papulosis (LyP) with extensive lesions
(d) Mycosis fungoides (MF)/Sezary syndrome (SS)

Authorization will be issued for 12 months.

2. Reauthorization

a. **Valchlor** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Valchlor

Authorization will be issued for 12 months.

B. NCCN Recommended Regimens

1. Initial Authorization

a. **Valchlor** will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium.

Authorization will be issued for 12 months.

2. Reauthorization

a. **Valchlor** will be approved based on the following criterion:

(1) Documentation of positive clinical response to Valchlor therapy

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Valchlor [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation.; January 2020.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed July 30, 2020.

Program	Prior Authorization - Valchlor gel for topical use (mechlorethamine)
Change Control	
Date	Change
3/2014	New Criteria

12/2015	Annual Review
9/2016	Updated clinical criteria to align with E&I notification policy and updated policy template.
9/2017	Annual Review. Updated criteria for fungoides/sezary syndrome. Updated references.
9/2018	Updated NHL criteria per NCCN. Added NCCN Recommended Regimen review criteria. Updated references.
9/2019	Changed NHL to Primary Cutaneous Lymphomas and revised coverage criteria to align with NCCN. Updated references.
9/2020	Annual review. No changes to coverage criteria. Added Additional Clinical Rules section. Updated references.