I. Medication Description

Mechlorethamine, also known as nitrogen mustard, is an alkylating agent which inhibits rapidly proliferating cells. While mechlorethamine for topical administration has traditionally been a compounded medication, Valchlor is the first FDA-approved topical formulation of this medication.

II. Position Statement

Coverage is determined through a prior authorization process with supporting clinical documentation for all requests.

III. Policy

Coverage of Valchlor is available when the following criteria have been met:

- The medication is prescribed by a hematologist/oncologist AND
- The requested use is supported by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines (NCCN Guidelines®) and/or NCCN Drugs & Biologics Compendium (NCCN Compendium®) with a recommendation of category level 1 or 2A.

IV. Quantity Limitations

Coverage is provided for one 60g tube every 30 days.

V. Coverage Duration

Coverage is granted for 6 months and may be renewed.

VI. Coverage Renewal Criteria

Coverage can be renewed based upon the following criteria:

- Stabilization of disease or in absence of disease progression AND
- Absence of unacceptable toxicity from the drug

VII. Billing/Coding Information

- Available in 60g tubes of 0.016% mechlorethamine (0.02% mechlorethamine HCl)
- Pertinent Indications:
  - NHL – Adult T-cell Leukemia/Lymphoma: C91.50, C91.51
  - NHL – Mycosis Fungoides/Sezary Syndrome: C84.00-C84.09
  - NHL – Primary Cutaneous B-Cell Lymphoma: C82.60-C82.69, C83.80-C83.89, C88.4, Z85.72
  - NHL – Primary Cutaneous CD30+ T-cell Lymphoproliferative Disorders: C86.6, Z85.72
VIII. Summary of Policy Changes

- 12/15/13: new policy
- 1/1/15: no policy changes
- 7/1/15: formulary distinctions made
- 3/15/16: updated coverage to coincide with current NCCN treatment guidelines
- 1/1/17: no policy changes
- 1/1/18: coverage criteria updated to allow use as supported by current NCCN guidelines
- 1/15/19: no policy changes

IX. References


The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

The preceding policy applies only to members for whom the above named pharmacy benefit medications are included on their covered formulary. Members with closed formulary benefits are subject to trying all appropriate formulary alternatives before a coverage exception for a non-formulary medication will be considered.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.