Allogeneic processed thymus tissue–agdc (Rethymic ®)

These services may or may not be covered by your HealthPartners plan. Please see your plan documents for your specific coverage information. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage.

Administrative Process

Allogeneic Processed Thymus Tissue–agdc (Rethymic ®) requires prior authorization from Healthpartners Pharmacy Administration.

Coverage

Rethymic is generally covered subject to the indications listed below when all of the following criteria are met, and per member plan documents.

Initial Authorizations

1. Prescribed by a specialist, **and**
2. For immune reconstitution in pediatric patients with congenital athymia, **and**
3. The diagnosis of congenital athymia is based on flow cytometry docum,enting fewer than 50 naïve T cells/mm3 (CD45RA+, CD62L+) in the peripheral blood or less than 5% of total T cells being naïve in phenotype, **and**
4. Patient has complete DiGeorge syndrome (cDGS; also referred to as complete DiGeorge anomaly (cDGA)), **and**
5. Rethymic will not be used for the treatment of patients with severe combined immunodeficiency (SCID), **and**
6. Rethymic will not be used in patients with heart surgery anticipated within 4 weeks prior to, or 3 months after, the planned Rethymic treatment date, in patients with human immunodeficiency virus (HIV) infection, or in patients who are not considered good surgical candidates, **and**
7. Rethymic is prescribed within the FDA-approved dosing regimen

Coverage will be provided for one dose only.

Definitions

Rethymic ® (allogeneic processed thymus tissue–agdc) is indicated for immune reconstitution in pediatric patients with congenital athymia.

Congenital athymia is a rare condition characterized by the absence of a thymus at birth.

Codes

If available, codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive.

The services associated with these codes require prior authorization:

HCPCS

Codes	Description
C9399	Unclassified drugs or biologicals (Hospital Outpatient Use **only**)
J3590	Unclassified biologics

NDC Codes

Codes	Description
72359-0001-01	Allogenic Thymocyte-depleted Thymus Tissue-agdc

Products

This information is for most, but not all, HealthPartners plans. Please read your plan documents to see if your plan has limits or will not cover some items. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage. These coverage criteria do not apply to Medicare Products. For more information regarding Medicare coverage criteria or for a copy of a Medicare coverage policy, contact Member Services at 952-883-7272 or 1-877-778-8384.

Approved by Pharmacy & Therapeutics Committee: 5/9/2022. Annual Review 4/1/2023, 4/1/2024, 4/1/2025

References

1. Rethymic prescribing information.