

Clinical Policy Title:	mechlorethamine gel
Policy Number:	RxA.534
Drug(s) Applied:	Valchlor®
Original Policy Date:	03/06/2020
Last Review Date:	12/11/2025
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Mycosis Fungoides (must meet all):

1. Diagnosis is stage IA - IB
2. Trial & Failure of at least one skin-directed therapy unless contraindicated or clinically significant adverse effects are experienced.

Initial Approval Duration

All Lines of Business (except Medicare): 6 months

II. Continued Therapy Approval

A. Mycosis Fungoides (must meet all):

1. Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria.

Approval Duration

All Lines of Business (except Medicare): 12 months

References

1. National Comprehensive Cancer Network. Primary Cutaneous Version 3.2024. Available at: <https://www.nccn.org/guidelines/guidelines-detail?category=1&id=1491>. Accessed October 11, 2024.
2. National Comprehensive Cancer Network. T-Cell Lymphomas Version 4.2024. Available at: <https://www.nccn.org/guidelines/guidelines-detail?category=1&id=1483>. Accessed October 11, 2024.
3. National Comprehensive Cancer Network. Histiocytic Neoplasms Version 2.2024. Available at: <https://www.nccn.org/guidelines/guidelines-detail?category=1&id=1502>. Accessed October 11, 2024.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	03/06/2020
Policy was reviewed: <ol style="list-style-type: none"> 1. Clinical Policy Title Table was updated. 2. Line of business policy applies was updated to All lines of business. 3. Continued Therapy criteria II.A.1 was rephrased to "Member is currently receiving 	10/14/2020	12/07/2020

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

<p>medication that has been authorized by RxAdvance..."</p> <ol style="list-style-type: none"> 4. Initial Approval criteria: Medicaid approval duration was updated from Length of Benefit to 6 months. 5. Continued Approval criteria: Medicaid approval duration was updated from Length of Benefit to 6 months. 6. References was reviewed and updated. 		
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> 1. Initial Approval Criteria I.B.1.d & I.B.1.e added to include off label indications "Unifocal Langerhans Cell Histiocytosis". 2. References was reviewed and updated. 	09/25/2021	12/07/2021
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> 1. References were reviewed and updated. 	09/13/2022	10/19/2022
<p>Policy was reviewed.</p>	10/19/2023	10/19/2023
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> 1. Removed age restrictions. 2. Removed prescriber restrictions. 3. Removed dose restrictions. 4. Updated Continued therapy approval with "Member is currently receiving medication that has been authorized by RxAdvance...." 5. References were reviewed and updated. 	10/16/2024	12/05/2024
<p>Policy reviewed.</p>	12/11/2025	12/11/2025