

## PRIOR AUTHORIZATION POLICY

**POLICY:** Oncology – Valchlor Prior Authorization Policy

- Valchlor® (mechlorethamine topical gel – Helsinn)

**REVIEW DATE:** 11/30/2022

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### OVERVIEW

Valchlor, a nitrogen mustard, is 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.<sup>1</sup>

### Guidelines

Valchlor is addressed in National Comprehensive Cancer Network guidelines:

- **Histiocytic neoplasms:** Guidelines (version 1.2022 – May 20, 2022) recommend Valchlor for the topical treatment of unifocal Langerhans cell histiocytosis with isolated skin disease.<sup>2,5</sup>
- **Primary cutaneous lymphomas:** Guidelines (version 2.2022 – June 8, 2022) recommend Valchlor for the topical treatment of primary cutaneous B-cell lymphoma, mycosis fungoides/Sezary syndrome, and primary cutaneous CD30+ T-cell lymphoproliferative disorders.<sup>2,3</sup>
- **T-cell lymphomas:** Guidelines (version 2.2022 – March 7, 2022) recommend Valchlor for the topical treatment of adult T-cell leukemia/lymphoma – chronic/smoldering subtype.<sup>2,4</sup>

### POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Valchlor. All approvals are provided for the duration noted below.

**Automation:** None.

### RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Valchlor is recommended in those who meet one of the following criteria:

#### FDA-Approved Indication

1. **Cutaneous Lymphomas.** Approve for 1 year if the patient is  $\geq 18$  years of age.  
Note: Includes mycosis fungoides/Sezary syndrome, primary cutaneous B-cell lymphoma, primary cutaneous CD30+ T-cell lymphoproliferative disorders.

#### Other Uses with Supportive Evidence

2. **Adult T-Cell Leukemia/Lymphoma.** Approve for 1 year if the patient has chronic/smoldering subtype of adult T-cell leukemia/lymphoma.
3. **Langerhans Cell Histiocytosis.** Approve for 1 year if, according to the prescriber, patient has unifocal Langerhans cell histiocytosis with isolated skin disease.

### CONDITIONS NOT RECOMMENDED FOR APPROVAL

11/30/2022

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Coverage of Valchlor is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

#### **REFERENCES**

1. Valchlor® topical gel [prescribing information]. Iselin, NJ: Helsinn; January 2020.
2. The NCCN Drugs and Biologics Compendium. © 2022 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on November 15, 2022. Search term: mechlorethamine.
3. The NCCN Primary Cutaneous Lymphomas Clinical Practice Guidelines in Oncology (version 2.2022 – June 8, 2022). © 2022 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on November 15, 2022.
4. The NCCN T-Cell Lymphomas Clinical Practice Guidelines in Oncology (version 2.2022 – March 7, 2022). © 2022 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on November 15, 2022.
5. The NCCN Histiocytic Neoplasms Clinical Practice Guidelines in Oncology (version 1.2022 – May 20, 2022). © 2022 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed November 15, 2022.