Provider Network News

Prior Authorization Criteria for Ryoncil Effective Oct. 1, 2025

Background

On Oct. 1, 2025, Ryoncil will become a benefit of Medicaid and CHIP. HHSC requires prior authorization of Ryoncil (procedure code J3402) for Medicaid and CHIP, effective for dates of service on or after Nov. 1, 2025.

Key Details

Ryoncil (remestemcel-L-rknd) is an allogenic bone marrow-derived mesenchymal stromal cell (MSC) therapy approved to treat steroid-refractory acute graft versus host disease (SRaGVHD) in pediatric patients 2 months of age and older.

Prior Authorization Requirements

Prior authorization approval for an intravenous infusion of Ryoncil (remestemcel-L-rknd) J3402 will be considered when the following criteria are met:

- Patient is at least 2 months or older
- Patient has a confirmed diagnosis of aGVHD (diagnosis code – D89.810) following an allogenic hematopoietic stem cell transplant
- Patient has no known hypersensitivity to dimethyl sulfoxide or porcine and bovine proteins, and their aGVHD is steroid-refractory, as documented by the following:
    - Progression of acute GVHD within 3 days of consecutive treatment with 2 mg/kg/day of methylprednisolone or equivalent
    - No signs of improvement within 7 days of therapy with 2mg/kg/day of methylprednisolone or equivalent treatment

Continuation Therapy

For continuation of Ryoncil therapy, PCHP will require providers to monitor the patient for the parameters listed below:

- Patient has received Ryoncil for at least 28 days
- Patient has documentation of partial or mixed response to Ryoncil treatment
- Patient is currently receiving or has received Ryoncil without any serious or life-threatening reactions

Action

PCHP will implement the criteria on or after Nov. 1, 2025.

Resources

Refer to the *Outpatient Drug Services Handbook* for more details on the clinical policy and prior authorization requirements.

Policy or Operational Documents: **TMPPM Outpatient Drug Services Handbook**