Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: 02/01/2021**
Policy Number: PA.CP.PHAR.410	**Effective Date: 01/01/2018** **Revision Date: 01//2021**
Policy Name: Bortezomib (Velcade)	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ✓ **Revised Policy***
- ☐ **Annual Review - No Revisions**
- ☐ **Statewide PDL -** *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

1Q 2021 annual review: AIDS-related Kaposi sarcoma pediatric HL NCCN recommended uses added; references reviewed and updated.

Name of Authorized Individual (Please type or print): **Auren Weinberg, MD**	**Signature of Authorized Individual:** 

Clinical Policy: Bortezomib (Velcade)

Reference Number: PA.CP.PHAR.410
Effective Date: 01.2019
Last Review Date: 01.2021

Coding Implications
Revision Log

Description
Bortezomib (Velcade®) is a proteasome inhibitor.

FDA Approved Indication(s)Velcade is indicated for treatment of patients with:
- multiple myeloma (MM)
- mantle cell lymphoma (MCL)

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with PA Health & Wellness® that Velcade is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Multiple Myeloma and Mantle Cell Lymphoma (must meet all)**:**

1. Diagnosis of one of the following (a or b):
   a. MM;
   b. MCL (B-cell lymphoma subtype);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Request meets one of the following (a or b):
   a. Dose does not exceed 1.3 mg/m^2;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

B. NCCN Recommended Uses (off-label) (must meet all)**:**

1. Diagnosis of one of the following (a, b, c, d, e, f, g, or h):
   a. Kaposi sarcoma - as subsequent systemic therapy, given alone (no HIV) or with antiretroviral therapy (ART) for people with HIV (PWH), for relapsed/refractory advanced cutaneous, oral, visceral, or nodal disease that has progressed on or not responded to first-line systemic therapy, and progressed on alternate first-line systemic therapy;
   b. Multicentric Castleman's disease (B-cell lymphoma subtype) - as subsequent therapy;
   c. Systemic light chain amyloidosis;
   d. Adult T-cell leukemia/lymphoma - as subsequent therapy;
   e. Waldenström macroglobulinemia/lymphoplasmacytic lymphoma;
   f. Pediatric acute lymphoblastic leukemia (ALL) - as subsequent therapy;

g. Pediatric Hodgkin lymphoma (HL) - as subsequent therapy in combination with ifosafamide and vinorelbine;
h. Other category 1, 2A, or 2B NCCN-recommended uses not listed;

2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years (all indications except pediatric ALL and HL);
4. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

C. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Currently receiving medication via Pennsylvania Health and Wellness benefit or member has previously met all initial approval criteria or the Continuity of Care policy (PA.LTSS.PHAR.01) applies;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):
   a. New dose does not exceed 1.3 mg/m^2;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Pennsylvania Health and Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA.LTSS.PHAR.01) applies.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – PA.CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALL: acute lymphoblastic leukemia

NCCN: National Comprehensive Cancer Network

FDA: Food and Drug Administration

HL: Hodgkin lymphoma
MCL: mantel cell lymphoma
MM: multiple myeloma

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s):
  - Patients with hypersensitivity (not including local reactions) to bortezomib, boron, or mannitol, including anaphylactic reactions
  - Contraindicated for intrathecal administration
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MM	• First-line therapy: 1.3 mg/m^2 as a 3 to 5 second bolus IV injection or SC injection in combination with PO melphalan and PO prednisone for nine 6-week treatment cycles. • Relapse*: 1.3 mg/m^2 as a 3 to 5 second bolus IV injection or SC injection as a single agent or in combination with dexamethasone for up to eight 3-week cycles. For therapy beyond eight cycles, see PI for additional dosing options. *If relapse occurs ≥ 6 months after a previous response to Velcade, treatment may be restarted at the last tolerated dose.	1.3 mg/m^2
MCL	• First-line therapy: 1.3 mg/m^2 as a 3 to 5 second bolus IV injection or SC injection in combination with IV rituximab, cyclophosphamide, doxorubicin and PO prednisone (VcR-CAP) for up to six 3-week treatment cycles, plus two additional cycles if a positive response. • Relapse: 1.3 mg/m^2 as a 3 to 5 second bolus IV injection or SC injection for up to eight 3-week treatment cycles. Therapy may extend beyond eight cycles.	1.3 mg/m^2

VI. Product Availability
10 mL vials for reconstitution containing 3.5 mg of bortezomib as a cake or powder.

VII. References
1. Velcade Prescribing Information. Cambridge, MA: Millennium Pharmaceuticals, Inc.; April 2019. Available at: http://www.velcade.com/files/PDFs/VELCADE_PRESCRIBING_INFORMATION.pdf. Accessed November 11, 2020.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed November 10, 2020.

3. National Comprehensive Cancer Network. Multiple Myeloma Version 3.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf. Accessed November 11, 2020.
4. National Comprehensive Cancer Network. B-Cell Lymphomas Version 4.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed November 11, 2020.
5. National Comprehensive Cancer Network. Systemic Light Amyloidosis Version 1.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/amyloidosis.pdf. Accessed November 11, 2020.
6. National Comprehensive Cancer Network. T-Cell Lymphomas Version 1.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/t-cell.pdf. Accessed November 11, 2020.
7. National Comprehensive Cancer Network. Waldenström Macroglobulinemia / Lymphoplasmacytic Lymphoma Version 1.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/waldenstroms.pdf. Accessed November 11, 2020.
8. National Comprehensive Cancer Network. Pediatric Acute Lymphoblastic Leukemia Version 2.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ped_all.pdf. Accessed November 11, 2020.
9. National Comprehensive Cancer Network. Pediatric Hodgkin Lymphoma Version 2.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ped_hodgkin.pdf. Accessed November 11, 2020.
10. National Comprehensive Cancer Network. AIDS-Related Kaposi Sarcoma Version 3.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/kaposi.pdf. Accessed November 11, 2020.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9041	Injection, bortezomib, 0.1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	01/2019	
1Q 2020 annual review: references reviewed and updated.	01/2020	
1Q 2021 annual review: AIDS-related Kaposi sarcoma pediatric HL NCCN recommended uses added; references reviewed and updated.	01/2021	