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: 11/01/2025**
Policy Number: PA.CP.PHAR.307	**Effective Date: 01/2018** **Revision Date: 10/2025**
Policy Name: Bendamustine (Belrapzo, Bendeka, Treanda, Vivimusta)	

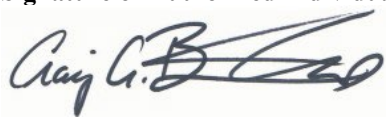
Type of Submission – Check all that apply:

- ☐ **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:

4Q 2025 annual review: for all indications, extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; for off-label NCCN uses per NCCN, added off-label indications of T-PLL and TFH lymphoma and removed mycosis fungidoes/Sezary syndrome; references reviewed and updated.

Name of Authorized Individual (Please type or print): **Craig A. Butler, MD MBA**	**Signature of Authorized Individual:** 

Clinical Policy: Bendamustine (Belrapzo, Bendeka, Treanda, Vivimusta)

Reference Number: PA.CP.PHAR.307
Effective Date: 01/2018
Last Review Date: 10/2025

Description
Bendamustine hydrochloride (Belrapzo®, Bendeka®, Treanda®, Vivimusta™) is an alkylating drug.

FDA Approved Indication(s)
Belrapzo, Bendeka, Treanda, and Vivimusta are indicated for the treatment of patients with:
- Chronic lymphocytic leukemia (CLL); Efficacy relative to first line therapies other than chlorambucil has not been established
- Indolent B-cell non-Hodgkin lymphoma (NHL) that has progressed during or within six months of treatment with rituximab or a rituximab-containing regimen

Policy/Criteria
It is the policy of PA Health & Wellness ® that Belrapzo, Bendeka, Treanda, Vivimusta and bendamustine are medically necessary when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (must meet all)**:**
1. Diagnosis of CLL or small lymphocytic lymphoma (SLL);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Prescribed in combination with rituximab or Gazyva®;
5. Request meets one of the following (a or b):
   a. Dose does not exceed 100 mg/m^2 on Days 1 and 2 of a 28-day cycle for up to 6 cycles;
   b. 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. Non-Hodgkin B-Cell Lymphomas (must meet all)**:**
1. Diagnosis of one of the following (a-i):
   a. Indolent B-cell non-Hodgkin lymphoma that has progressed during or within six months of treatment with rituximab or a rituximab-containing regimen;
   b. Classic follicular lymphoma;
   c. Marginal zone lymphoma (MZL) (i, ii or ii):
      i. Splenic MZL;
      ii. Nodal MZL
      iii. Extranodal mucosa-associated lymphoid tissues (MALT) (1 or 2):
         1) Gastric MALT lymphoma;
         2) Nongastric MALT lymphoma;
   d. Mantle cell lymphoma;

e. Diffuse large B-cell lymphoma(DLBCL) with no intention to proceed to transplant (*as subsequent therapy*);*
f. HIV-related B-cell lymphoma (*as subsequent therapy*);*
g. Monomorphic post-transplant lymphoproliferative disorder (PTLD) (B-cell type) (*as subsequent therapy*);*
h. High-grade B-cell lymphomas;
i. Other NCCN recommendations listed as category 1, 2A, or 2B;

**See Appendix B - prior authorization may be required for prior therapies*

2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. For classical follicular lymphoma, MZL: prescribed in combination with rituximab or Gazyva;
5. For mantle cell lymphoma, prescribed in combination with one of the following (a-d):
   a. Rituximab;
   b. Calquence with rituximab;
   c. Cytarabine with rituximab;
   d. Other NCCN recommendations listed as category 1, 2A, or 2B;
6. For indolent B-cell non-Hodgkin lymphoma, DLBCL, HIV-related B-cell lymphoma, PTLD, high-grade B-cell lymphomas: prescribed in combination with Polivy® with or without rituximab;
7. Request meets one of the following (a or b):
   a. Dose does not exceed 120 mg/m^2 on Days 1 and 2 of a 21-day cycle for up to 8 cycles;
   b. 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

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

1. Diagnosis of one of the following (a-h):
   a. Hodgkin lymphoma (HL),as subsequent therapy;*
   b. Pediatric HL that is relapsed or refractory, as re-induction or subsequent therapy;*
   c. Hematopoietic cell transplantation for NHL without central nervous system (CNS) disease or for HL;
   d. Multiple myeloma (MM) that is relapsed or refractory, as subsequent therapy after 3 prior therapies;*
   e. One of the following T-cell lymphomas (i-v):
      i. Adult T-cell leukemia/lymphoma (ATLL), as subsequent therapy;*
      ii. Hepatosplenic T-cell lymphoma (HSTCL), as subsequent therapy;*
      iii. Breast implant-associated ALCL, as subsequent therapy;*
      iv. T-cell prolymphocytic leukemia (T-PLL);
      v. One of the following peripheral T-cell lymphoma (PTCL) subtypes, as initial palliative intent therapy or subsequent treatment therapy (1-8):
         1) Peripheral T-cell lymphoma not otherwise specified (PTCL-NOS);
         2) Angioimmunoblastic T-cell lymphoma (AITL),
         3) Anaplastic large cell lymphoma (ALCL);
         4) Enteropathy-associated T-cell lymphoma (EATL),

5) Follicular T-cell (TFH) lymphoma;
6) Follicular helper T-cell (TFH) lymphoma;
7) Monomorphic epitheliotropic intestinal T-cell lymphoma (MEITL),
8) Nodal PTCL with TFH phenotype;

f. Systemic light chain amyloidosis (SLCA) that is relapsed/refractory;
g. Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma (including management of Bing–Neel syndrome);
h. Other NCCN recommendations listed as category 1, 2A, or 2B;

**See Appendix B - prior authorization may be required for prior therapies*

2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years, unless diagnosis is pediatric HL;
4. For hematopoietic cell transplantation, prescribed in combination with etoposide, cytarabine, and melphalan;
5. For T-cell lymphomas: prescribed as a single agent or in combination with Adcentris®;
6. For SLCA: prescribed in combination with dexamethasone;
7. For Waldenstrom's macroglobulinemia: prescribed as a single agent or in combination with rituximab;
9. 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: 12 months

B. 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 Approval

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

1. Currently receiving medication via PA Health & Wellness benefit or member has previously met all initial approval criteria or the Continuity of Care policy (PA.PHARM.01) applies;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets (a or b):
   a. New dose does not exceed (i or ii):
      i. CLL/SLL: 100 mg/m^2 on Days 1 and 2 of a 28-day cycle for up to 6 cycles;
      ii. Non-Hodgkin indolent B-cell lymphoma: 120 mg/m^2 on Days 1 and 2 of a 21-day cycle for up to 8 cycles;
   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 PA Health & Wellness benefit and documentation supports positive response to therapy; or the Continuity of Care policy (PA.PHARM.01) applies; or
2. Refer to 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 policies – PA.CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AITL: angioimmunoblastic T-cell lymphoma
ALCL: anaplastic large cell lymphoma
ATLL: adult T-cell leukemia/lymphoma
CLL: chronic lymphocytic leukemia
CNS: central nervous system
DLBCL: diffuse large B-cell lymphoma
EATL: enteropathy-associated T-cell lymphoma
FDA: Food and Drug Administration
FTCL: follicular T-cell lymphoma
HIV: human immunodeficiency virus
HL: Hodgkin lymphoma
HSTCL: hepatosplenic gamma-delta T-cell lymphoma
MF: mycosis fungoides
MALT: mucosa-associated lymphoid tissue
MEITL: monomorphic epitheliotropic intestinal T-cell lymphoma
MM: multiple myeloma
MCL: marginal zone lymphoma
NCCN: National Comprehensive Cancer Network
NHL: non-Hodgkin lymphoma
PTCL: peripheral T-cell lymphoma
PTLD: post-transplant lymphoproliferative disorder
PTLD-NOS: post-transplant lymphoproliferative disorder not otherwise specified
SLCA: systemic light chain amyloidosis
SLL: small lymphocytic lymphoma
TFH: T-cell follicular helper T-cell

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Examples of primary therapies (NCCN)		
B-cell NHL (e.g. DLBCL, HIV-related B-cell lymphoma, PTCL)		
RCHOP Rituxan® (rituximab) + cyclophosphamide, doxorubicin, vincristine, prednisone)	Varies	Varies
EPOCH	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
(etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin) + Rituxan® (rituximab)		
RCDOP Rituxan® (rituximab) + (cyclophosphamide, liposomal doxorubicin, vincristine, prednisone)	Varies	Varies
RCEOP Rituxan® (rituximab) + (cyclophosphamide, etoposide, vincristine, prednisone)	Varies	Varies
RGCVP Rituxan® (rituximab) + (gemcitabine, cyclophosphamide, vincristine, prednisone)	Varies	Varies
RCEPP Rituxan® (rituximab) + (cyclophosphamide, etoposide, prednisone, procarbazine)	Varies	Varies
Pola-R-CHP (Polivy [polatuzumab vedotin-piiq], Rituxan [rituximab], cyclophosphamide, doxorubicin, prednisone)	Varies	Varies
HL		
ABVD (doxorubicin, bleomycin, vinblastine, dacarbazine) + Rituxan (rituximab)	Varies	Varies
RCHOP Rituxan (rituximab) + (cyclophosphamide, doxorubicin, vincristine, prednisone)	Varies	Varies
CVbp (cyclophosphamide, vinblastine, prednisolone) + Rituxan (rituximab)	Varies	Varies
Rituxan (rituximab)	Varies	Varies
MM		
Bortezomib/lenalidomide/dexamethasone	Varies	Varies
Carfilzomib/lenalidomide/dexamethasone	Varies	Varies
Daratumumab/lenalidomide/dexamethasone	Varies	Varies
T-cell Lymphomas (e.g. HSTCL, ATLL)		
ICE (ifosfamide, carboplatin, etoposide)	Varies	Varies
DHAP (dexamethasone, andcisplatin, cytarabine) + platinum (carboplatin, cisplatin, or oxaliplatin)	Varies	Varies
EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin) + Rituxan (rituximab)	Varies	Varies
HyperCVAD (cyclophosphamide, vincristine, doxorubicin, dexamethasone) alternating with high-dose methotrexate and cytarabine	Varies	Varies
CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, prednisone)	Varies	Varies
CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone)	Varies	Varies
Polivy (brentuximab vedotin) ± CHP (cyclophosmaide, doxorubicin, prednisone)	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Belrapzo, Bendeka: patients with a history of a hypersensitivity reaction to bendamustine, polyethylene glycol 400, propylene glycol, or monothioglycerol
  - Treanda: patients with a history of a hypersensitivity reaction to bendamustine
  - Vivimusta: patients with a history of a hypersensitivity reaction to bendamustine, polyethylene glycol 400, dehydrated alcohol, or monothioglycerol
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CLL/SLL*	Bendeka: 100 mg/m^2 IV over 10 minutes on Days 1 and 2 of a 28-day cycle, up to 6 cycles Belrapzo, Treanda: 100 mg/m^2 IV over 30 minutes on days 1 and 2 of a 28-day cycle, up to 6 cycles Vivimusta: 100 mg/m^2 IV over 20 minutes on Days 1 and 2 of a 28-day cycle, up to 6 cycles	See regimen
Indolent B-cell lymphoma*	Bendeka: 120 mg/m^2 IV over 10 minutes on Days 1 and 2 of a 21-day cycle, up to 8 cycles Belrapzo, Treanda: 120 mg/m^2 IV over 60 minutes on days 1 and 2 of a 21-day cycle, up to 8 cycles Vivimusta: 120 mg/m^2 IV over 20 minutes on Days 1 and 2 of a 21-day cycle, up to 8 cycles	See regimen

**Non-Hodgkin lymphomas*

VI. Product Availability

Drug Name	Availability
Bendamustine (Belrapzo, Bendeka, Vivimusta)	Solution (multiple-dose vial): 100 mg/4 mL
Bendamustine (Treanda)	Lyophilized powder (single-dose vial): 25 mg in a 20 mL vial; 100 mg in a 20 mL vial

VII. References

1. Belrapzo Prescribing Information. Woodcliff Lake, NJ: Eagle Pharmaceuticals, Inc; January2024. Available at: www.belrapzo.com. Accessed July 6, 2025.

2. Bendeka Prescribing Information. Parsippany, NJ: Teva Pharmaceuticals; January 2024. Available at www.bendekahcp.com. Accessed July 6, 2025.
3. Treanda Prescribing Information. Parsippany, NJ: Teva Pharmaceuticals; October 2022. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/022249s026lbl.pdf. Accessed July 6, 2025.
4. Vivimusta Prescribing Information. Princeton, NJ: Slayback Pharma; February 2024. Available at: www.vivimusta.com.Accessed July 6, 2025.
5. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. July 16, 2025.
6. National Comprehensive Cancer Network. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma Version 3.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cll.pdf. July 16, 2025.
7. National Comprehensive Cancer Network. B-cell Lymphomas Version 2.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. July 16, 2025.
8. National Comprehensive Cancer Network. Hodgkin Lymphoma Version 2.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/hodgkins.pdf. July 16, 2025.
9. National Comprehensive Cancer Network. Multiple Myeloma Version 2.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf. July 16, 2025.
10. National Comprehensive Cancer Network. T-cell Lymphomas Version 2.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/t-cell.pdf. July 16, 2025.
11. National Comprehensive Cancer Network. Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma Version 1.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/waldenstroms.pdf. July 16, 2025.

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
J9033	Injection, bendamustine HCl (Treanda), 1 mg
J9034	Injection, bendamustine HCl (Bendeka), 1 mg
J9036	Injection, bendamustine HCl, (Belrapzo), 1 mg
J9056	Injection, bendamustine hydrochloride (vivimusta), 1 mg

Reviews, Revisions, and Approvals	Date
4Q 2018 annual review: summarized NCCN and FDA-approved uses for improved clarity; added specialist involvement in care; added PTLD (category 2A recommendation) as a covered indication per NCCN compendium; updated continued therapy section to include language for continuity of care; references reviewed and updated.	07/2018
4Q 2019 annual review: No changes per Statewide PDL implementation 01-01-2020	10/2019

HCPCS Codes	Description	
	4Q 2020 annual review: off-label criteria sets combined into one - additional criteria limited to subsequent therapy requirement; added additional therapeutic alternatives to Appendix B with NCCN category 1: MM; added hepatosplenic gamma-delta T-cell lymphoma to non-Hodgkin T-cell lymphomas (off-label) uses and related therapeutic alternatives to Appendix B; appendix B prior therapy examples truncated; references reviewed and updated.	10/2020
	4Q 2021 annual review: added Belrapzo; per NCCN category 2A recommendations: added requirements for combination use for CLL, MALT lymphoma, and marginal zone lymphoma; clarified types of PTCLs; removed gamma delta requirement from HSTCL; added off-label indications of breast-implant ALCL, nodular lymphocyte-predominant HL, pediatric HL, and high-grade B-cell lymphomas; for off-label indications, revised age requirement to allow bypass if diagnosis is pediatric HL; references reviewed and updated.	10/2021
	4Q 2022 annual review: added SLCA and hematopoietic cell transplantation under NCCN recommended use given category 2A recommendation; removed primary cutaneous lymphomas as use is no longer supported by NCCN primary cutaneous lymphoma guideline; references reviewed and updated.	10/2022
	RT4: added new dosage form Vivimusta	01/2023
	4Q 2023 annual review: removed combination use with Arzerra for CLL from initial criteria as use is no longer supported by NCCN CLL/SLL guideline; renamed AIDS-related B-cell lymphoma to HIV-related per NCCN naming changes; references reviewed and updated.	11/2023
	4Q 2024 annual review: clarified that policy applies to generic bendamustine; for all indications, revised commercial approval duration to "6 months or to the member's renewal date, whichever is longer"; for NHL per NCCN, clarified follicular lymphoma is classic, updated formatting for MZL to clarify types; specified DLBL is with no intention to proceed to transplant, revised high-grade B-cell lymphoma criteria to lymphoma with no intention to proceed to transplant, added requirements for combination use for classic follicular lymphoma, MZL, indolent NHL, DLBCL, HIV-related B-cell lymphoma, PTLD, and high-grade B-cell lymphoma per NCCN; for off-label NCCN uses per NCCN, added relapsed or refractory requirements to HL, MM, and SLCA, added as subsequent therapy requirement to MM and PTCL, added initial therapy requirement to PTCL; added off-label indications of MF/SS, EATL, and ALCL, clarified PTCL subtypes, clarified Waldenstrom's macroglobulinemia includes Bing-Neel syndrome, added requirements for combination use for T-cell lymphomas, MF/SS, and Waldenstrom's macroglobulinemia; updated Appendix B per NCCN; removed bendamustine 45mg and 180mg vials per product discontinuation; removed inactive HCPCS codes; references reviewed and updated.	10/2024

HCPCS Codes	Description	
	4Q 2025 annual review: for all indications, extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; for off-label NCCN uses per NCCN, added off-label indications of T-PLL and TFH lymphoma and removed mycosis fungidoes/Sezary syndrome; references reviewed and updated.	10/2025