Kyprolis (carfilzomib)

Line(s) of Business:
HMO; PPO; QUEST Integration
Medicare Advantage

Original Effective Date:
10/01/2015
Current Effective Date:
12/01/2018

POLICY

A. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no contraindications or exclusions to the prescribed therapy.

FDA-Approved Indications

- Kyprolis is indicated in combination with dexamethasone or with lenalidomide plus dexamethasone for the treatment of patients with relapsed or refractory multiple myeloma who have received one to three lines of therapy.
- Kyprolis is indicated as a single agent for the treatment of patients with relapsed or refractory multiple myeloma who have received one or more lines of therapy.

Compendial Uses

- Primary therapy for active (symptomatic) myeloma or for disease relapse after 6 months following primary induction therapy with the same regimen in combination with
  - dexamethasone and lenalidomide
  - dexamethasone and cyclophosphamide for non-transplant candidates
- Therapy for previously treated disease for disease relapse, for disease progression, or for refractory disease:
  - given twice weekly in combination with dexamethasone (preferred regimen)
  - in combination with dexamethasone and lenalidomide (preferred regimen)
  - in combination with dexamethasone and cyclophosphamide
  - given weekly in combination with dexamethasone
  - in combination with panobinostat (Farydak) in patients who have received at least two prior regimens, including bortezomib and an immunomodulatory agent
  - in combination with pomalidomide and dexamethasone for patients who have received at least two prior therapies, including an immunomodulatory agent and a proteasome inhibitor, and have demonstrated disease progression on or within 60 days of completion of the last therapy
- Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma macroglobulinemia/lymphoplasmacytic lymphoma
  - used as a component of CaRD (carfilzomib, rituximab, and dexamethasone) regimen
  - as primary therapy
  - for relapse ≥24 months if used as primary therapy

B. REQUIRED DOCUMENTATION

The following information is necessary to initiate the prior authorization review:

- For initial therapy
  - Current oncology notes, clinical notes (including previous treatment history), and any pertinent pathology reports and/or imaging studies supporting the diagnosis of unresectable or metastatic melanoma
  - Documentation of previous regimens
- For continuation therapy
  - Documentation demonstrating lack of disease progression on therapy (e.g, clinical notes, laboratory tests, and any pertinent pathology reports and/or imaging studies)

C. PRESCRIBER RESTRICTION

The medication must be prescribed by, or in conjunction with, an oncologist or hematologist

D. EXCLUSIONS

Members who do not have active multiple myeloma. Active multiple myeloma is defined as clonal bone marrow plasma cells ≥10% or biopsy-proven extramedullary plasmacytoma AND having at least one of the following myeloma-defining events:

- Serum calcium greater than 11 mg/dl or more than 1 mg/dL above upper limit of normal
- Serum creatinine greater than 2 mg/dl or creatinine clearance less than 40 ml/min
- Hemoglobin less than 10 g/dl or more than 2 g/dl below lower limit of normal
- One or more osteolytic bone lesions on X-ray, CT or PET/CT
- Clonal bone marrow plasma cells ≥60%
- Abnormal serum FLC ratio ≥100 (involved kappa) or ≤0.01 (involved lambda)
- More than one focal lesion on MRI studies ≥5 mm

E. CRITERIA FOR APPROVAL

1. Multiple Myeloma

a. Authorization of 6 months may be granted for members who have had disease relapse after 6 months following primary induction therapy
   - Kyprolis with dexamethasone and lenalidomide
   - Kyprolis with dexamethasone and cyclophosphamide for non-transplant candidates

b. Authorization of 6 months may be granted for members prescribed Kyprolis for the treatment of previously treated, relapsed, progressive, or refractory multiple myeloma in one of the following regimens:
   - Kyprolis given twice weekly in combination with dexamethasone
   - Kyprolis in combination with dexamethasone and lenalidomide (Revlimid)
   - Kyprolis in combination with dexamethasone and cyclophosphamide
   - Kyrpolis given weekly in combination with dexamethasone
   - Kyrpolis in combination with panobinostat (Farydak) in patients who have received at least two prior regimens including Velcade (bortezomib) and an immunomodulatory agent
   - Kyprolis in combination with Pomalyst (pomalidomide) and dexamethasone in members who have received at least 2 prior regimens including an immunomodulatory agent (eg, Revlimid, Thalomid) and a proteasome inhibitor (eg, Velcade) and have demonstrated disease progression on or within 60 days of completion of the last therapy.

2. Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma
Authorization of 6 months may be granted for members who are prescribed Kyprolis in combination with CaRD (carfilzomib, rituximab and dexamethasone) who meet either of the following criteria:
- The medication will be used as primary therapy, OR
- used as primary therapy if the relapse is greater than, or equal to, 24 months

F. DOSING AND ADMINISTRATION
Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

G. CONTINUATION OF THERAPY
1. No previous authorization/precertification:
   All members (including new members and members currently receiving treatment without prior authorization) must meet criteria for initial approval in section E.
2. Reauthorization:
   Members who were previously approved for Kyprolis by CVS/HMSA may request reauthorizations after their initial approval. Approval for an additional 3 months may be granted if the following information is supplied:
   - A current oncology notes documenting the member's response to treatment showing no progression of disease
   - Current imaging studies and other objective measures (e.g., beta-2 microglobulin, serum free light chain assay, or serum immunoglobulin) showing no progression of disease when compared with previous results

H. ADMINISTRATIVE GUIDELINES
Precertification is required. Please refer to the HMSA medical policy web site for the fax form.

I. IMPORTANT REMINDER
The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii's Patients' Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA/CVS's determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

J. REFERENCES
1. Kyprolis [package insert]. Thousand Oaks, CA: Amgen; January 2018.

2. The NCCN Drugs & Biologics Compendium™. © 2018 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed March 21st 2018.
3. NCCN Clinical Practice Guidelines in Oncology. Multiple Myeloma Version 2.2018 – March 21, 2018. https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf. Accessed March 21, 2018.

Document History

10/01/2015	Original effective date
03/28/2016	Added new FDA-approved combination
11/30/2016	Annual review
05/01/2017	Revision effective date
08/2017	Annual Review
03/01/2018	Revision effective date
04/01/2018	Annual Review
06/11/2018	Updated Policy
12/01/2018	Revision effective date