Velcade (bortezomib)

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

Original Effective Date: 03/09/2004
Effective Date: 10/01/2015

POLICY
A. INDICATIONS
The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications
- Treatment of patients with multiple myeloma.
- Treatment of patients with mantle cell lymphoma

Compendial Uses
- Active (symptomatic) multiple myeloma
  - Primary therapy in combination with dexamethasone, dexamethasone and cyclophosphamide, dexamethasone and doxorubicin, dexamethasone and lenalidomide, or dexamethasone and thalidomide for stem cell transplant candidates
  - Primary therapy in combination with dexamethasone, or melphalan and prednisone for non-transplant candidates
  - Maintenance therapy as monotherapy
  - Salvage therapy as monotherapy, or in combination with dexamethasone, dexamethasone and lenalidomide, dexamethasone and cyclophosphamide, dexamethasone and thalidomide, dexamethasone and panobinostat, liposomal doxorubicin, vorinostat, or as part of a combination regimen with dexamethasone, thalidomide, cisplatin, doxorubicin, cyclophosphamide, and etoposide (VTD-PACE), for patients who will not be treated with the same therapy as primary therapy
  - Salvage therapy in combination with dexamethasone, dexamethasone and cyclophosphamide, dexamethasone and doxorubicin, dexamethasone and lenalidomide, or dexamethasone and thalidomide for patients who were transplant candidates and will be treated with the same regimen as primary therapy
  - Salvage therapy in combination with dexamethasone, or melphalan and prednisone for patients who were non-transplant candidates and will be treated with the same regimen as primary therapy
- Systemic light chain amyloidosis as a single agent or in combination with dexamethasone, dexamethasone and melphalan, or dexamethasone and cyclophosphamide
• Waldenström’s macroglobulinemia/lymphoplasmacytic lymphoma as a single agent, or in combination with dexamethasone, rituximab, or rituximab and dexamethasone
• Mantle cell lymphoma
  o Less aggressive induction therapy with VR-CAP (bortezomib, rituximab, cyclophosphamide, doxorubicin, and prednisone) regimen
  o Second-line therapy with or without rituximab for relapsed, refractory, or progressive disease

B. REQUIRED DOCUMENTATION
The following information is necessary to initiate the prior authorization review:
• The patient’s treatment plan with treatment regimen including dose, frequency, length of each cycle, number of cycles, and additional therapies (e.g., other medications, radiation) must be documented.
• Relevant laboratory reports, imaging studies, and office notes to substantiate status and progression of disease

C. PRESCRIBER RESTRICTION
The medication must be prescribed by, or in conjunction with, an oncologist or hematologist.

D. CRITERIA FOR APPROVAL
1. Systemic light chain amyloidosis
   a. Authorization of 6 months may be granted for members prescribed Velcade as primary therapy for the treatment of systemic light chain amyloidosis in combination with ANY of the following regimens:
      i. Monotherapy
      ii. Dexamethasone
      iii. Dexamethasone and cyclophosphamide
      iv. Dexamethasone and melphalan

2. Waldenström’s macroglobulinemia/lymphoplasmacytic lymphoma
   a. Authorization of 6 months may be granted for members prescribed Velcade for the treatment of Waldenström’s macroglobulinemia/lymphoplasmacytic lymphoma in combination with ANY of the following regimens:
      i. Monotherapy
      ii. Dexamethasone
      iii. Rituximab
      iv. Dexamethasone and rituximab

3. Active (symptomatic) multiple myeloma
   a. Authorization of 6 months may be granted for members prescribed Velcade as primary therapy for the treatment of multiple myeloma in patients who are eligible for stem cell transplant in combination with ANY of the following regimens:
      i. Dexamethasone
      ii. Dexamethasone and cyclophosphamide
      iii. Dexamethasone and doxorubicin
      iv. Dexamethasone and lenalidomide
      v. Dexamethasone and thalidomide
b. Authorization of 6 months may be granted for members prescribed Velcade as primary therapy for the treatment of multiple myeloma in patients who are NOT eligible for stem cell transplant in combination with:
   i. Dexamethasone, OR
   ii. Melphalan and prednisone

c. Authorization of 6 months may be granted for members prescribed Velcade as maintenance therapy for the treatment of multiple myeloma as monotherapy

d. Authorization of 6 months may be granted for members prescribed Velcade as salvage therapy for the treatment of multiple myeloma as part of ANY of the following regimens for patients who will NOT be receiving the same regimen as their primary chemotherapy regimen:
   i. As monotherapy
   ii. In combination with dexamethasone
   iii. In combination with dexamethasone and lenalidomide
   iv. In combination with dexamethasone and cyclophosphamide
   v. In combination with dexamethasone and thalidomide
   vi. In combination with liposomal doxorubicin
   vii. In combination with vorinostat
   viii. In combination with dexamethasone, thalidomide, cisplatin, doxorubicin, cyclophosphamide, and etoposide (VTD-PACE)
   ix. In combination with dexamethasone and panobinostat

e. Authorization of 6 months may be granted for members prescribed Velcade as salvage therapy for the treatment of multiple myeloma as part of ANY of the following regimens in patients who will be receiving the same therapy as their primary chemotherapy, were transplant candidates, and the relapse occurred at least 6 months after their primary chemotherapy:
   i. Dexamethasone
   ii. Dexamethasone and cyclophosphamide
   iii. Dexamethasone and doxorubicin
   iv. Dexamethasone and lenalidomide
   v. Dexamethasone and thalidomide

f. Authorization of 6 months may be granted for members prescribed Velcade as salvage therapy for the treatment of multiple myeloma as part of ANY of the following regimens in patients who will be receiving the same therapy as their primary chemotherapy, were NOT transplant candidates, and the relapse occurred at least 6 months after their primary chemotherapy:
   i. Dexamethasone
   ii. Melphalan and prednisone

4. Mantle Cell Lymphoma
   a. Authorization of 6 months may be granted for members prescribed Velcade for induction therapy for mantle cell lymphoma as part of the VR-CAP (bortezomib, rituximab, cyclophosphamide, doxorubicin, and prednisone) regimen

   b. Authorization of 6 months may be granted for members prescribed Velcade for second-line therapy for mantle cell lymphoma with or without rituximab for relapsed, refractory, or progressive disease
E. CONTINUATION OF THERAPY
All members, including new members, requesting authorization for therapy must meet ALL initial authorization criteria.

Members who were previously approved for Velcade by HMSA may request reauthorizations after their initial approval. Approval for an additional 6 months may be granted if the following information is supplied and the member does not demonstrated evidence of disease progression:

- A current oncology note documenting the patient’s response to treatment showing no progression of disease
- Current laboratory reports (e.g., beta-2 microglobulin, serum free light chain assay, or serum immunoglobulin) or other objective measures showing no progression of disease when compared with previous results

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. 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’s determination as to medical necessity in a given case, the physician may request that CVS/caremark reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

H. REFERENCES