Clinical Policy: Carfilzomib (Kyprolis)

Reference Number: CP.PHAR.309
Effective Date: 02/17
Last Review Date: 02/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The intent of the criteria is to ensure that patients follow selection elements established by Centene® clinical policy for carfilzomib (Kyprolis®).

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that Kyprolis is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Multiple Myeloma (must meet all):

1. Diagnosis of multiple myeloma (MM);
2. Meets a or b:
   a. FDA approved use (i, ii and iii):
      i. MM is relapsed or refractory;
      ii. Member has received ≥ 1 prior therapy;
      iii. Kyprolis is prescribed in one of the following ways (a or b):
         a) In combination with dexamethasone or lenalidomide plus dexamethasone;
         b) As a single agent;
   b. Off-label NCCN recommended use:
      i. MM is active (symptomatic) or relapsed/progressive/refractory;
      ii. Kyprolis is prescribed in one of the following ways:
         a) If active MM, in combination with lenalidomide and dexamethasone as either of the following:
            1) Primary/first-line therapy;
            2) Therapy for relapsed disease after 6 months following primary therapy with the same regimen;
         b) If relapsed, progressive or refractory MM, either of the following (1 or 2):
            1) In combination with pomalidomide and dexamethasone, and (i and ii):
               i) Member has received ≥ 2 prior therapies including an immunomodulatory agent (e.g., thalidomide, lenalidomide) and a proteasome inhibitor (e.g., ixazomib, bortezomib);
               ii) Demonstrated disease progression on or within 60 days of completion of the last therapy;
            2) In combination with panobinostat, and:
               i) Member has received ≥ 2 prior therapies including bortezomib and an immunomodulatory agent.

Approval duration: 3 months

B. Other diagnoses/indications: Refer to CP.PHAR.57 - Global Biopharm Policy.
1. The following NCCN recommended uses for Kyprolis, meeting NCCN categories 1, 2a, or 2b, are approved per the CP.PHAR.57 Global Biopharm Policy:
   a. Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma.

II. Continued Approval

A. Multiple Myeloma (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. No disease progression or unacceptable toxicity.

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy; or
2. Refer to CP.PHAR.57 - Global Biopharm Policy**.**

Background

Description/Mechanism of Action:
Carfilzomib is a tetrapeptide epoxyketone proteasome inhibitor that irreversibly binds to the N-terminal threonine-containing active sites of the 20S proteasome, the proteolytic core particle within the 26S proteasome. Carfilzomib had antiproliferative and proapoptotic activities in vitro in solid and hematologic tumor cells. In animals, carfilzomib inhibited proteasome activity in blood and tissue and delayed tumor growth in models of multiple myeloma, hematologic, and solid tumors.

Formulations:
Kyprolis (carfilzomib) is supplied as a lyophilized cake or powder for reconstitution available as follows:
- Single-dose vial containing 30 mg of carfilzomib
- Single-dose vial containing 60 mg of carfilzomib

FDA Approved Indications:
Kyprolis is a proteasome inhibitor/intravenous formulation 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.
- As a single agent for the treatment of patients with relapsed or refractory multiple myeloma who have received one or more lines of therapy.

Appendices

Appendix A: Abbreviation Key
MM: Multiple myeloma

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
J9047	Injection, carfilzomib, 1 mg

Reviews, Revisions, and Approvals	Date	Approval Date
Policy split from CP.PHAR.182 Excellus Oncology.	01/17	02/17

References

1. Kyprolis prescribing information. Thousand Oaks, CA: Onyx Pharmaceuticals, Inc.; November 2016. Available at http://pi.amgen.com/~/media/amgen/repositorysites/pi-amgen-com/kyprolis/kyprolis_pi.ashx. Accessed January 11, 2017.
2. Carfilzomib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at NCCN.org. Accessed January 11, 2017.
3. Multiple myeloma (Version 3.2017). In: National Comprehensive Cancer Network Guidelines. Available at NCCN.org. Accessed January 10, 2017.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and

regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.