Clinical Policy: Carfilzomib (Kyprolis)

Reference Number: CP.PHAR.309
Effective Date: 02.01.17
Last Review Date: 11.17
Line of Business: Medicaid

Coding Implications
Revision Log

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

Description
Carfilzomib (Kyprolis®) is a proteasome inhibitor inhibitor.

FDA Approved Indication(s)
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.
- As a single agent for the treatment of patients with relapsed or refractory multiple myeloma who have received one or more lines of therapy.

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval 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. Age ≥ 18 years;
3. Request meets (a or b):
   a. FDA approved use (i or ii):
      i. In combination with dexamethasone or with lenalidomide plus dexamethasone for relapsed or refractory myeloma after one to three lines of therapy;
      ii. As a single agent for relapsed or refractory myeloma after one or more lines of therapy;
   b. NCCN recommended use (i or ii):
      i. In combination with lenalidomide and dexamethasone for active (symptomatic) myeloma as (a or b):
         a) Primary therapy;
         b) Therapy for disease relapse after 6 months following primary therapy with the same regimen;

ii. Therapy for previously treated myeloma for disease relapse or for progressive or refractory disease in combination with (a, b or c):
   a) Dexamethasone with or without lenalidomide;
   b) Pomalidomide and dexamethasone after at least two prior therapies, including an immunomodulatory agent and a proteasome inhibitor, and demonstrated disease progression on or within 60 days of completion of the last therapy;
   c) Panobinostat after at least two prior regimens, including bortezomib and an immunomodulatory agent;

4. Request meets one of the following (a or b):
   a. Dose does not exceed 27 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. Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma (must meet all)**:**

1. Diagnosis of Waldenstrom's macroglobulinemia (i.e., lymphoplasmacytic lymphoma);
2. NCCN recommended use:
   a. As a component of CaRD (carfilzomib, rituximab, and dexamethasone) regimen (i or ii):
      i. As primary therapy;
      ii. For relapse ≥ 24 months if used as primary therapy;
3. 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

C. Other diagnoses/indications

1. Refer to CP.PHAR.57 for specialty if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

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

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy (e.g., no disease progression or unacceptable toxicity);
3. If request is for a dose increase, request meets one of the following (a or b):
   a. New dose does not exceed 27 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 Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to CP.PHAR.57 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 – CP.PHAR.57 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CaRD: carfilzomib, rituximab, dexamethasone
FDA: Food and Drug Administration
MM: multiple myeloma
NCCN: National Comprehensive Cancer Network

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MM	Kyprolis in combination with lenalidomide and Dexamethasone • Kyprolis intravenously as a 10-minute infusion on two consecutive days, each week for three weeks followed by a 12-day rest period as shown in Table 1. Each 28-day period is considered one treatment cycle. The recommended starting dose of Kyprolis is 20 mg/m^2 in Cycle 1 on Days 1 and 2. If tolerated, escalate the dose to 27 mg/m^2 on Day 8 of Cycle 1. From Cycle 13, omit the Day 8 and 9 doses of Kyprolis. Discontinue Kyprolis after Cycle 18. Lenalidomide 25 mg is taken orally on Days 1–21 and dexamethasone 40 mg by mouth or intravenously on Days 1, 8, 15, and 22 of the 28-day cycles. Kyprolis in combination with dexamethasone • Kyprolis intravenously as a 30-minute infusion on two consecutive days, each week for three weeks followed by a 12-day rest period. Each 28-day period is considered one treatment cycle. Administer Kyprolis by 30-minute infusion at a starting dose of 20 mg/m^2 in Cycle 1 on Days 1 and 2. If tolerated, escalate the dose to 56 mg/m^2 on Day 8 of Cycle 1. Dexamethasone 20 mg is taken by mouth or intravenously on Days 1, 2, 8, 9, 15, 16, 22, and	27 mg/m^2

	23 of each 28-day cycle. Administer dexamethasone 30 minutes to 4 hours before Kyprolis. _____ *Calculate the Kyprolis dose using the patient's actual body surface area at baseline. In patients with a body surface area greater than 2.2 m^2, calculate the dose based upon a body surface area of 2.2 m^2.*	

VI. Product Availability

Single-dose vial, 30 mg

VII. References

1. Kyprolis Prescribing Information. Thousand Oaks: Onyx Pharmaceuticals, Inc.; May 2017. Available at: http://pi.amgen.com/~/media/amgen/repositorysites/pi-amgen-com/kyprolis/kyprolis_pi.ashx. Accessed August 2017.
2. Carfilzomib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at nccn.org. Accessed August 2017.
3. Multiple myeloma (Version 3.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed August 2017.
4. Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma (Version 1.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed August 2017.

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	P&T Approval Date
Policy split from CP.PHAR.182 Excellus Oncology.	01.01.17	02.17
Age and dosing added Safety information removed. NCCN recommended uses added separately.	09.05.17	11.17

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.