Clinical Policy: Carfilzomib (Kyprolis)

Reference Number: CP.PHAR.309
Effective Date: 02.01.17
Last Review Date: 11.19
Line of Business: Commercial, HIM, 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.

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 (MM) who have received one to three lines of therapy.
- As a single agent for the treatment of patients with relapsed or refractory MM who have received one or more lines of therapy.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) 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 MM;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Kyprolis is prescribed in one of the following ways (a or b):*
   a. After prior therapy *(see Appendix B for examples of prior therapy)*;
      i. As a single-agent;
      ii. In combination with Farydak®;
      iii. In combination with dexamethasone ± Pomalyst®;
   b. In combination with dexamethasone and either Revlimid® or cyclophosphamide;

   **Prior authorization may be required.*
5. Request meets one of the following (a, b, c, or d):*
   a. Monotherapy: dose does not exceed 56 mg/m^2 twice weekly each 28-day cycle;
   b. With dexamethasone and Revlimid: dose does not exceed 27 mg/m^2 twice weekly 3 out of 4 weeks for twelve 28-day cycles, then 27 mg/m^2 twice weekly 2 out of 4 weeks for the next six 28-day cycles for up to a total of 18 cycles;
   c. With dexamethasone only: does not exceed (i or ii):
      i. 70 mg/m^2 once weekly each 28-day cycle;

ii. 56 mg/m^2 twice weekly each 28-day cycle;

d. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration: 6 months

B. Waldenstrom's Macroglobulinemia (Lymphoplasmacytic Lymphoma) (off-label) (must meet all)**:**

1. Diagnosis of Waldenstrom's macroglobulinemia (i.e., lymphoplasmacytic lymphoma) (WM/LPL);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed as a component of CaRD (carfilzomib, Rituxan®* [rituximab], and dexamethasone) regimen as primary or Kyprolis-relapsed therapy;
   **Prior authorization may be required.*
5. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).*
   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration: 6 months

C. 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): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Multiple Myeloma (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Kyprolis for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a, b, c, or d):*
   a. Monotherapy: new dose does not exceed 56 mg/m^2 twice weekly each 28-day cycle;
   b. With Revlimid plus dexamethasone: new dose does not exceed 27 mg/m^2 twice weekly 3 out of 4 weeks for twelve 28-day cycles, then 27 mg/m^2 twice weekly 2 out of 4 weeks for the next six 28-day cycles for up to a total of 18 cycles;
   c. With dexamethasone only: new does not exceed (i or ii):
      i. 70 mg/m^2 once weekly each 28-day cycle;
      ii. 56 mg/m^2 twice weekly each 28-day cycle;
   d. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).
      **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration: 12 months

B. Waldenstrom's Macroglobulinemia (Lymphoplasmacytic Lymphoma) (off-label) (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Kyprolis for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).*
**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration: 12 months

C. 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 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): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

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 – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid 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
WM/LPL: Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma

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 for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Farydak (panobinostat) Pomalyst (pomalidomide)	MM: Kyprolis in combination with Farydak, or dexamethasone +/- Pomalyst: • Regimens vary	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Revlimid (lenalidomide) Cyclophosphamide Dexamethasone	Kyprolis in combination with dexamethasone and either Revlimid or cyclophosphamide: • Regimens vary.	
Darzalex® (daratumumab) Empliciti® (elotuzumab) Kyprolis (carfilzomib) Ninlaro® (ixazomib) Revlimid (lenalidomide) Thalomid® (thalidomide) Velcade® (bortezomib)	MM: Examples of primary and subsequent therapy regimens: • Bendamustine • Bortezomib/doxorubicin/dexamethasone • Bortezomib/thalidomide/dexamethasone • Bortezomib/lenalidomide/dexamethasone • Bortezomib/cyclophosphamide/dexamethasone • Carfilzomib/lenalidomide/dexamethasone • Carfilzomib/cyclophosphamide/dexamethasone • Daratumumab/lenalidomide/dexamethasone • Dexamethasone/thalidomide/cisplatin/ doxorubicin/cyclophosphamide/bortezomib • Elotuzumab/lenalidomide/dexamethasone • Ixazomib/lenalidomide/dexamethasone • Lenalidomide/dexamethasone	Varies
Rituxan (rituximab) Kyprolis (carfilzomib) dexamethasone	WM/LPL: CaRD (carfilzomib, rituximab, and dexamethasone)	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/Black Box Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MM	Kyprolis + Dexamethasone: • Cycles: Kyprolis IV as a 30-minute infusion (28-day cycles). • Dose (once weekly 20/70 mg/m^2 regimen): ○ Starting dose of Kyprolis 20 mg/m^2. ○ If tolerated, escalate Kyprolis to 70 mg/m^2 on Day 8 of Cycle 1. ○ Dexamethasone: 40 mg PO or IV on Days 1, 8, 15 of all 28-day cycles and on Day 22 of Cycles 1-9.	70 mg/m^2

Indication	Dosing Regimen	Maximum Dose
	Kyprolis + Dexamethasone, OR **Monotherapy**: • Cycles: Kyprolis IV as a 30-minute infusion (28-day cycles). • Dose (twice weekly 20/56 mg/m^2 regimen): ○ Starting dose of Kyprolis 20 mg/m^2. ○ If tolerated, escalate Kyprolis to 56 mg/m^2 on Day 8 of Cycle 1. *Do not include if Monotherapy:* ○ Dexamethasone: 20 mg PO or IV on Days 1, 2, 8, 9, 15, 16, 22, and 23 of each 28-day cycle. Kyprolis + Revlimid + Dexamethasone, OR **Monotherapy**: • Cycles: Kyprolis IV as a 10-minute infusion for eighteen 28-day cycles. ○ A cycle includes: Kyprolis on Days 1 and 2 of each week for 3 weeks then 12 days off = 28 days. ○ Beginning Cycle 13, omit Kyprolis on Days 8 and 9 of each cycle. ○ Discontinue Kyprolis after Cycle 18. • Dose: ○ Starting dose of Kyprolis: 20 mg/m^2. ○ If tolerated, escalate Kyprolis to 27 mg/m^2 on Day 8 of Cycle 1. *Do not include if Monotherapy:* ○ Revlimid: 25 mg PO QD on Days 1–21 of each cycle. ○ Dexamethasone: 40 mg PO or IV on Days 1, 8, 15, and 22 of each 28-day cycle. *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.; February 2019. Available at: http://pi.amgen.com/~/media/amgen/repositorysites/pi-amgen-com/kyprolis/kyprolis_pi.ashx. Accessed August 7, 2019.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed August 7, 2019.
3. National Comprehensive Cancer Network. Multiple Myeloma Version 03.2019. Available at: https://www.nccn.org. Accessed July 22, 2019.

4. National Comprehensive Cancer Network. Waldenstrom's macroglobulinemia-lymphoplasmacytic lymphoma Version 02.2019. Available at: https://www.nccn.org. Accessed August 7, 2019.

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
4Q 2018 annual review: HIM-Medical added; NCCN and FDA-approved uses summarized for improved clarity; specialist involvement in care and continuation of care added; MM prior therapy regimens consolidated into primary or subsequent therapy; dexamethasone and cyclophosphamide added as an MM regimen; references reviewed and updated.	08.07.18	11.18
Commercial line of business added.	10.15.19	
4Q 2019 annual review: HIM line of business added; Kyprolis dosing as monotherapy and in combination with dexamethasone added per PI; references reviewed and updated.	08.20.19	11.19

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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the non-formulary policy; HIM.PA.103.