Clinical Policy: Belinostat (Beleodaq)

Reference Number: LA.PHAR.311
Effective Date:
Last Review Date: 06.15.23
Line of Business: Medicaid

Coding Implications
Revision Log

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

Please note: This policy is for medical benefit

Description
Belinostat (Beleodaq®) is a histone deacetylase inhibitor.

FDA Approved Indication(s)
Beleodaq is indicated for the treatment of patients with relapsed or refractory peripheral T-cell lymphoma (PTCL).

This indication is approved under accelerated approval based on tumor response rate and duration of response. An improvement in survival or disease-related symptoms has not been established. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trial.

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 Louisiana Healthcare Connections that Beleodaq is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Peripheral T-Cell Lymphoma (must meet all)**:**

1. Diagnosis of PTCL – (*see Appendix D for examples of PTCL subtypes*);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Request meets one of the following (a or b):*
   a. Dose does not exceed 1,000 mg/m^2 per day on days 1-5 of a 21-day cycle;
   b. 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. NCCN-Recommended Off-Label Indications (must meet all)**:**

1. Diagnosis of one of the following (a, b, c, d, or e):
   a. Primary cutaneous anaplastic large cell lymphoma (ALCL) with multifocal lesions, or cutaneous ALCL with regional nodes;

b. Adult T-cell leukemia/lymphoma;
c. Extranodal NK/T-cell lymphoma, nasal type;
d. Hepatosplenic gamma-delta T-cell lymphoma;
e. Breast implant ALCL;

2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Dose is within FDA maximum limit for any FDA-approved indication or 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 (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: LA.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Beleodaq 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 or b):*
   a. New dose does not exceed 1,000 mg/m^2 per day on days 1-5 of a 21-day cycle;
   b. 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. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: LA.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 policy – LA.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALCL: anaplastic large cell lymphoma
FDA: Food and Drug Administration
NCCN: National Comprehensive Cancer Network
PTCL: peripheral T-cell lymphoma

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information

- PTCL - subtypes/histologies:
  - PTCL, not otherwise specified;
  - Anaplastic large cell lymphoma;
  - Angioimmunoblastic T-cell lymphoma;
  - Enteropathy-associated T-cell lymphoma;
  - Monomorphic epitheliotropic intestinal T-cell lymphoma;
  - Nodal peripheral T-cell lymphoma with TFH phenotype;
  - Follicular T-cell lymphoma;

**PTLC is classified as a non-Hodgkin T-cell lymphoma. PTCL classification schemes are periodically advanced as new information becomes available; therefore, the above list is provided as general guidance. For additional information, see WHO's 2016 updated classification of hematological malignancies for a complete list of lymphoid neoplasms, including PTCL.*

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PTCL	1,000 mg/m^2 IV on days 1-5 of a 21-day cycle. Cycles can be repeated every 21 days until disease progression or unacceptable toxicity.	1,000 mg/m^2/day

VI. Product Availability

Single-dose vial: 500 mg

VII. References

1. Beleodaq Prescribing Information. Irvine, CA: Spectrum Pharmaceuticals, Inc.; April 2022. Available at: http://www.beleodaq.com/downloads/Beleodaq_PI.pdf. Accessed July 5, 2022.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed July 5, 2022.
3. National Comprehensive Cancer Network. T-Cell Lymphomas Version 2.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/t-cell.pdf. Accessed July 5, 2022.
4. National Comprehensive Cancer Network. Primary Cutaneous Lymphomas Version 2.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/primary_cutaneous.pdf. Accessed July 5, 2022.

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
J9032	Injection, belinostat, 10 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted corporate to local policy.	06.15.23	

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. LHCC 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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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 fnot 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 LHCC has no control or right of control. Providers are not agents or employees of LHCC.