

Clinical Policy: Carfilzomib (Kyprolis)

Reference Number: CP.PHAR.309

Effective Date: 02.01.17

Last Review Date: 11.18

Line of Business: Commercial, Medicaid, HIM-Medical Benefit

[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 \geq 18 years;
4. Kyprolis is prescribed in one of the following ways (a, b, or c):
 - a. As single agent subsequent therapy;
 - b. As combination subsequent therapy with Farydak[®], or dexamethasone with or without Pomalyst[®];
 - c. As primary or subsequent combination therapy with dexamethasone and either Revlimid[®] or cyclophosphamide;

**Prior authorization may be required for Farydak, Pomalyst and Revlimid.*

5. Request meets one of the following (a or b):
 - a. Dose does not exceed 27 mg/m² for eighteen 28-day cycles;
 - 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) (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 \geq 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 for Rituxan.*
5. Request meets one of the following (a or b):
 - c. Dose does not exceed 27 mg/m² for eighteen 28-day cycles;
 - d. 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 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. All Indications in Section I (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 or b):
 - a. New dose does not exceed 27 mg/m² for eighteen 28-day cycles;
 - 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 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) Revlimid (lenalidomide) Cyclophosphamide Dexamethasone	<u>MM:</u> <u>Kyprolis in combination with Farydak, or dexamethasone +/- Pomalyst:</u> • Regimens vary <u>Kyprolis in combination with dexamethasone and either Revlimid or cyclophosphamide:</u> • Regimens vary.	Varies
Darzalex [®] (daratumumab) Empliciti [®] (elotuzumab) Kyprolis (carfilzomib) Ninlaro [®] (ixazomib) Revlimid (lenalidomide) Thalomid [®] (thalidomide) Velcade [®] (bortezomib)	<u>MM: Examples of primary and subsequent therapy regimens:</u> • 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)	<u>WM/LPL: CaRD (carfilzomib, rituximab, and dexamethasone)</u>	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Kyprolis (carfilzomib) dexamethasone		

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	<p><u>Kyprolis with Revlimid and dexamethasone:</u></p> <ul style="list-style-type: none"> • Cycles: Kyprolis IV as a 10-minute infusion for eighteen 28-day cycles. <ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ○ Starting dose of Kyprolis: 20 mg/m². ○ If tolerated, escalate Kyprolis to 27 mg/m² on Day 8 of Cycle 1. ○ 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. <p><u>Kyprolis in combination with dexamethasone:</u></p> <ul style="list-style-type: none"> • Cycles: Kyprolis IV as a 30-minute infusion for eighteen 28-day cycles. • Dose: <ul style="list-style-type: none"> ○ Starting dose of Kyprolis 20 mg/m². ○ If tolerated, escalate Kyprolis to 56 mg/m² on Day 8 of Cycle 1. ○ Dexamethasone: 20 mg PO or IV on Days 1, 2, 8, 9, 15, 16, 22, and 23 of each 28-day cycle. <p><i>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 m², calculate the dose based upon a body surface area of 2.2 m².</i></p>	56 mg/m ²

VI. Product Availability

Single-dose vial: 30 mg

VII. References

1. Kyprolis Prescribing Information. Thousand Oaks: Onyx Pharmaceuticals, Inc.; June 2018. Available at: http://pi.amgen.com/~/media/amgen/repositoriesites/pi-amgen.com/kyprolis/kyprolis_pi.ashx. Accessed July 16, 2018.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed July 16, 2018.
3. National Comprehensive Cancer Network. Multiple Myeloma Version 04.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf. Accessed July 16, 2018.
4. National Comprehensive Cancer Network. Waldenstrom’s macroglobulinemia-lymphoplasmacytic lymphoma Version 01.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf. Accessed July 16, 2018.

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
Added Commercial line of business to policy.	10.08.19	

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

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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.

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