

Clinical Policy: Daratumumab (Darzalex)

Reference Number: CP.PHAR.310

Effective Date: 07.01.17

Last Review Date: 08.18

Line of Business: Medicaid, HIM-Medical Benefit

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Daratumumab (Darzalex[®]) is a CD38-directed cytolytic antibody.

FDA Approved Indication(s)

Darzalex is indicated for the treatment of adult patients with multiple myeloma (MM):

- In combination with lenalidomide and dexamethasone in newly diagnosed patients who are ineligible for autologous stem cell transplant and in patients with relapsed or refractory multiple myeloma who have received at least one prior therapy
- In combination with bortezomib, melphalan, and prednisone in newly diagnosed patients who are ineligible for autologous stem cell transplant
- In combination with bortezomib and dexamethasone in patients who have received at least one prior therapy
- In combination with pomalidomide and dexamethasone in patients who have received at least two prior therapies including lenalidomide and a proteasome inhibitor (PI)
- As monotherapy, in patients who have received at least three prior lines of therapy including a PI and an immunomodulatory agent or who are double-refractory to a PI and an immunomodulatory agent

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 Darzalex 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 or hematologist;
3. Age \geq 18 years;
4. Darzalex is prescribed in one of the following ways (a, b, c, d, or e):
 - a. In combination with either lenalidomide and dexamethasone or bortezomib and dexamethasone after at least one prior therapy;
 - b. As monotherapy after three prior lines of therapy including at least one agent from both of the following categories of agents (i and ii):
 - i. PI (e.g., ixazomib, bortezomib, carfilzomib);
 - ii. Immunomodulatory agent (e.g., thalidomide, lenalidomide);

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- c. As monotherapy in member who is double-refractory to a PI and an immunomodulatory agent;
 - d. In combination with pomalidomide and dexamethasone, after two prior therapies, including lenalidomine and a PI;
 - e. In combination with bortezomib, melphalan, and prednisone for newly diagnosed MM in member ineligible for autologous stem cell transplant;
 - f. In combination with lenalidomide and dexamethasone for newly diagnosed MM in member ineligible for autologous stem cell transplant;
5. Request meets one of the following (a or b):
- a. Dose does not exceed the maximum indicated regimen in section V;
 - 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. 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.PMN.53 for Medicaid and HIM-Medical Benefit.

II. Continued Therapy**A. Multiple Myeloma (must meet all):**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Darzalex 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 the maximum indicated regimen in section V;
 - 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. Currently receiving medication via health plan 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.PMN.53 for Medicaid and HIM-Medical Benefit.

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.PMN.53 for Medicaid and HIM-Medical Benefit, or evidence of coverage documents.

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IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

MM: multiple myeloma

NCCN: National Comprehensive Cancer Network

PI: proteasome inhibitor

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
Ninlaro [®] (ixazomib)	4 mg PO on days 1, 8, and 15 of every 28-day treatment cycle	See dosing regimen
bortezomib (Velcade [®])	1.3 mg/m ² SC or IV; frequency of administration varies based on specific use	See dosing regimen
Kyprolis [®] (carfilzomib)	20 mg/m ² , 27 mg/m ² , and/or 56 mg/m ² IV; frequency of administration varies based on specific use	See dosing regimen
Revlimid [®] (lenalidomide)	10 mg or 25 mg PO QD; dose and frequency of administration vary based on specific use	See dosing regimen
Thalomid [®] (thalidomide)	100 mg, 200 mg, or 400 mg PO QD; dose and frequency of administration vary based on specific use	See dosing regimen

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/Boxed Warnings

- Contraindication(s): hypersensitivity
- Boxed Warning(s): none reported

Appendix D: General Information

- Double-refractory: refractory, or did not respond, to both a PI and an immunomodulatory agent after being previously exposed to the agents

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MM – monotherapy	<u>Weeks 1 to 8:</u> 16 mg/kg IV weekly <u>Weeks 9 to 24:</u> 16 mg/kg IV every 2 weeks <u>Weeks 25 onwards until disease progression:</u> 16 mg/kg IV every 4 weeks	See dosing regimen

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Indication	Dosing Regimen	Maximum Dose
MM – after at least one prior therapy	<p>In combination with lenalidomide and low-dose dexamethasone: <u>Weeks 1 to 8:</u> 16 mg/kg IV weekly <u>Weeks 9 to 24:</u> 16 mg/kg IV every 2 weeks <u>Weeks 25 onwards until disease progression:</u> 16 mg/kg IV every 4 weeks</p> <p>In combination with bortezomib and dexamethasone: <u>Weeks 1 to 9:</u> 16 mg/kg IV weekly <u>Weeks 10 to 24:</u> 16 mg/kg IV every 3 weeks <u>Weeks 25 onwards until disease progression:</u> 16 mg/kg IV every 4 weeks</p>	See dosing regimen
MM – after at least two prior therapies	<p>In combination with pomalidomide and low-dose dexamethasone: <u>Weeks 1 to 8:</u> 16 mg/kg IV weekly <u>Weeks 9 to 24:</u> 16 mg/kg IV every 2 weeks <u>Weeks 25 onwards until disease progression:</u> 16 mg/kg IV every 4 weeks</p>	See dosing regimen
MM – newly diagnosed	<p>In combination with bortezomib, mephalan, and prednisone: <u>Weeks 1 to 6:</u> 16 mg/kg IV weekly <u>Weeks 7 to 54:</u> 16 mg/kg IV every 3 weeks <u>Weeks 55 onwards until disease progression:</u> 16 mg/kg IV every 4 weeks</p> <p>In combination with lenalidomide and low-dose dexamethasone: <u>Weeks 1 to 8:</u> 16 mg/kg IV weekly <u>Weeks 9 to 24:</u> 16 mg/kg IV every 2 weeks <u>Weeks 25 onwards until disease progression:</u> 16 mg/kg IV every 4 weeks</p>	See dosing regimen

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VI. Product Availability

Single-dose vial: 100 mg/5 mL, 400 mg/20 mL

VII. References

1. Darzalex Prescribing Information. Horsham, PA: Janssen Biotech, Inc.; June 2019. Available at <https://www.darzalex.com>. Accessed June 27, 2019.
2. Daratumumab. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.NCCN.org. Accessed May 16, 2018.
3. Lee HC, Shah JJ, and Orlowski RZ. Novel approaches to treatment of double-refractory multiple myeloma. Am Soc Clin Oncol Educ Book. 2013: 302-306. Doi: 10.1200/EdBook_AM.2013.33.e302.
4. National Comprehensive Cancer Network. Multiple Myeloma Version 4.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf. Accessed May 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
J9145	Injection, daratumumab, 10 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.182 Excellus Oncology.	01.17	02.17
Policy converted to new template. -Re-organized appropriately prescribed regimen in initial criteria; defined double-refractory in footnote -Added new indication: In combination with pomalidomide and dexamethasone for the treatment of patients with MM who have received at least two prior therapies including lenalidomide and a PI.	07.17	11.17
Policy converted to new template. Annual review – no clinical changes.	08.17	11.17
Criteria added for new FDA indication: combination use with bortezomib, mephalan, and prednisone for the treatment of newly diagnosed MM patients ineligible for autologous stem cell transplant; HIM-Medical benefit added; prescriber requirement added; references reviewed and updated.	05.29.18	08.18
RT4: Criteria added for new FDA indication: in combination with lenalidomide and dexamethasone in newly diagnosed MM patients	06.27.19	

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
who are ineligible for autologous stem cell transplant; references reviewed and updated.		

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.

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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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