Clinical Policy: Bortezomib (Velcade)

Reference Number: LA.PHAR.410
Effective Date:
Last Review Date: 03.21
Line of Business: Medicaid

Coding Implications
Revision Log

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

Description

Bortezomib (Velcade®) is a proteasome inhibitor.

FDA Approved Indication(s)

Velcade is indicated for treatment of patients with:

- **multiple myeloma (MM)**
- **mantle cell lymphoma (MCL)**

Policy/Criteria

Prior authorization is required. 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 Velcade is medically necessary when the following criteria are met:

I. Initial Approval Criteria

A. Multiple Myeloma and Mantle Cell Lymphoma (must meet all):

1. **Diagnosis of one of the following (a or b):**
   a. **MM;**
   b. **MCL (B-cell lymphoma subtype);**
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 1.3 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*).**

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

Approval duration:
Medicaid – 6 months

B. NCCN Recommended Uses (off-label) (must meet all):

1. **Diagnosis of one of the following (a, b, c, d, e, f, or g):**

a. **AIDS-related Kaposi sarcoma (advanced cutaneous, oral, visceral, or nodal disease) - prescribed in combination with antiretroviral therapy after ≥ 2 prior lines of systemic therapy;**
b. **Multicentric Castleman's disease (B-cell lymphoma subtype) - as subsequent therapy;**
c. **Systemic light chain amyloidosis;**
d. **Adult T-cell leukemia/lymphoma - as subsequent therapy;**
e. **Waldenström macroglobulinemia/lymphoplasmacytic lymphoma;**
f. **Pediatric acute lymphoblastic leukemia (ALL) - as subsequent therapy;**
g. **Pediatric Hodgkin lymphoma (HL) - as subsequent therapy in combination with ifosafamide and vinorelbine;**

2. **Prescribed by or in consultation with an oncologist or hematologist;**
3. **Age ≥ 18 years (all indications except pediatric ALL and HL);**
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:
Medicaid – 6 months

C. **Other diagnoses/indications**
1. **Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): 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 Velcade 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 1.3 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*).**
Prescribed regimen must be FDA-approved or recommended by NCCN.

Approval duration:
Medicaid – 12 months

B. **Other diagnoses/indications (must meet 1 or 2):**
1. **Currently receiving medication via Louisiana Healthcare Connections 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 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): 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

ALL: acute lymphoblastic leukemia
FDA: Food and Drug Administration
HL: Hodgkin lymphoma
MCL: mantel cell lymphoma
MM: multiple myeloma
NCCN: National Comprehensive Cancer Network

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- **Contraindication(s):**
  - **Patients with hypersensitivity (not including local reactions) to bortezomib, boron, or mannitol, including anaphylactic reactions**
  - **Contraindicated for intrathecal administration**
- **Boxed warning(s): none reported**

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MM	• First-line therapy: 1.3 mg/m^2 as a 3 to 5 second bolus IV injection or SC injection in combination with PO melphalan and PO prednisone for nine 6-week treatment cycles. • Relapse*: 1.3 mg/m^2 as a 3 to 5 second bolus IV injection or SC injection as a single agent or in combination with dexamethasone for up to eight 3-week cycles. For therapy beyond eight cycles, see PI for additional dosing options. **If relapse occurs ≥ 6 months after a previous response to Velcade, treatment may be restarted at the last tolerated dose.*	1.3 mg/m^2
MCL	• First-line therapy: 1.3 mg/m^2 as a 3 to 5 second bolus IV injection or SC injection in combination with IV rituximab, cyclophosphamide, doxorubicin and PO	1.3 mg/m^2

Indication	Dosing Regimen	Maximum Dose
	prednisone (VcR-CAP) for up to six 3-week treatment cycles, plus two additional cycles if a positive response. • Relapse: 1.3 mg/m^2 as a 3 to 5 second bolus IV injection or SC injection for up to eight 3-week treatment cycles. Therapy may extend beyond eight cycles.	

VI. Product Availability

10 mL vials for reconstitution containing 3.5 mg of bortezomib as a cake or powder.

VII. References

1. Velcade Prescribing Information. Cambridge, MA: Millennium Pharmaceuticals, Inc.; April 2019. Available at: http://www.velcade.com/files/PDFs/VELCADE_PRESCRIBING_INFORMATION.pdf. Accessed November 11, 2020.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed November 10, 2020.
3. National Comprehensive Cancer Network. Multiple Myeloma Version 3.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf. Accessed November 11, 2020.
4. National Comprehensive Cancer Network. B-Cell Lymphomas Version 4.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed November 11, 2020.
5. National Comprehensive Cancer Network. Systemic Light Amyloidosis Version 1.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/amyloidosis.pdf. Accessed November 11, 2020.
6. National Comprehensive Cancer Network. T-Cell Lymphomas Version 1.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/t-cell.pdf. Accessed November 11, 2020.
7. National Comprehensive Cancer Network. Waldenström Macroglobulinemia / Lymphoplasmacytic Lymphoma Version 1.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/waldenstroms.pdf. Accessed November 11, 2020.
8. National Comprehensive Cancer Network. Pediatric Acute Lymphoblastic Leukemia Version 2.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ped_all.pdf. Accessed November 11, 2020.
9. National Comprehensive Cancer Network. Pediatric Hodgkin Lymphoma Version 2.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ped_hodgkin.pdf. Accessed November 11, 2020.

10. **National Comprehensive Cancer Network. AIDS-Related Kaposi Sarcoma Version 3.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/kaposi.pdf. Accessed November 11, 2020.**

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
J9041	Injection, bortezomib, 0.1 mg

Reviews, Revisions, and Approvals	Date
Converted corporate to local policy	03.2021

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.

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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.

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