Pharmacy Policy Bulletin: J-0803 Miscellaneous Immunomodulators – Commercial and Healthcare Reform	
Number: J-0803	**Category:** Prior Authorization
Line(s) of Business: ☒ Commercial ☒ Healthcare Reform ☐ Medicare	**Benefit(s):** **Commercial:** **Prior Authorization (1.)** **1.** Miscellaneous Specialty Drugs Oral = Yes w/ Prior Authorization **Healthcare Reform:** Not Applicable
Region(s): ☒ All ☐ Delaware ☐ New York ☐ Pennsylvania ☐ West Virginia	**Additional Restriction(s):** None
Version: J-0803-009	**Original Date:** 09/07/2005
Effective Date: 10/28/2024	**Review Date:** 10/02/2024

Drugs Product(s):	• Thalomid (thalidomide) • Revlimid (lenalidomide) • Pomalyst (pomalidomide) • Farydak (panobinostat)

FDA-Approved Indication(s):	• **Thalomid (thalidomide)**
	  • Treatment of patients with newly diagnosed multiple myeloma, in combination with dexamethasone
	  • Acute treatment of cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL)
	  • Maintenance therapy for the prevention and suppression of cutaneous manifestations of ENL recurrence
	Revlimid (lenalidomide)
	  • Treatment of adult patients with multiple myeloma, in combination with dexamethasone
	  • Treatment of adult patients with multiple myeloma, as maintenance following autologous hematopoietic stem cell transplantation (auto-HSCT)
	  • Treatment of adult patients with transfusion dependent anemia due to low or intermediate-1 risk myelodysplastic syndromes (MDS) associated with a 5-q deletion abnormality with or without additional cytogenetic abnormalities
	  • Treatment of adult patients with mantle cell lymphoma (MCL) whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib
	  • Treatment of adult patients with previously treated follicular lymphoma (FL), in combination with a rituximab product
	  • Treatment of adult patients with previously treated marginal zone lymphoma (MZL), in combination with a rituximab product
	Pomalyst (pomalidomide)
	  • Treatment of adult patients in combination with dexamethasone, for patients with multiple myeloma who have received at least 2 prior therapies including lenalidomide and a proteasome inhibitor (bortezomib, carfilzomib, ixazomib) and have demonstrated disease progression on or within 60 days of completion of the last therapy

	• Treatment of adult patients with AIDS-related Kaposi sarcoma (KS) after failure of highly active antiretroviral therapy (HAART) or in patients with KS who are HIV-negative **Farydak (panobinostat)** • In combination with bortezomib and dexamethasone for the treatment of patients with multiple myeloma who have received at least 2 prior regimens, including bortezomib and an immunomodulatory agent (thalidomide, lenalidomide, pomalidomide)

Background:	• Thalomid is thought to exert its immunomodulatory, anti-inflammatory, and antiangiogenic effects decreasing circulating levels of TNF-a in patients with ENL; and activating T-cells to produce IL-2, which augments NK-dependent cytotoxic activation. Thalomid carries a black box warning for embryo-fetal toxicity and venous thromboembolism. • Revlimid exerts its immunomodulatory, antiangiogenic, and antineoplastic properties by targeting substrate proteins Aiolos, Ikaros, and CK1a for ubiquitination and degradation. Revlimid causes activation of T-cells and NK cells, which leads to antibody-dependent cell-mediated toxicity via interleukin-2 and interferon-gamma. In multiple myeloma cells, the combination of Revlimid and dexamethasone synergizes inhibition of cell proliferation and induces apoptosis. Revlimid carries a black box warning for embryo-fetal toxicity, hematologic toxicity, and venous and arterial thromboembolism. • Pomalyst targets substrate proteins Aiolos and Ikaros for ubiquitination and degradation, which has cytotoxic and immunomodulatory effects. Pomalyst enhances T-cell and NK cell-mediated immunity. Pomalyst carries a black box warning for embryo-fetal toxicity and venous and arterial thromboembolism. • Farydak is a histone deacetylase (HDAC) inhibitor. When HDAC is inhibited, acetylated histones and other proteins accumulate and cell cycle arrest and/or apoptosis are induced. Farydak carries a black box warning for severe diarrhea and cardiac toxicities. • Prescribing Considerations: o Thalomid is not indicated as monotherapy for cutaneous manifestations of ENL treatment in the presence of moderate to severe neuritis. o Revlimid is not indicated and is not recommended for the treatment of patients with chronic lymphocytic leukemia (CLL) outside of controlled clinical trials. o Use of Pomalyst for the treatment of Kaposi sarcoma was approved by the FDA under an accelerated approved based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s). o Thalomid, Revlimid, Pomalyst, and Farydak are all subject to Risk Evaluation and Mitigation Strategies (REMS) programs.

Approval Criteria

I. Initial Authorization

A. Thalomid

When a benefit, coverage of Thalomid may be approved when the following criterion is met **(1.)**:

1. The member meets one (1) of the following **(a., b., or c.):**

a. The member has a diagnosis of multiple myeloma (ICD-10 C90.0).

b. The member has a diagnosis of cutaneous manifestations of moderate to severe ENL (ICD-10 L52).

c. The member is being prescribed Thalomid for ENL prophylaxis (No ICD-10 Code).

B. Revlimid (lenalidomide)

1. **Multiple Myeloma**
   When a benefit, coverage of Revlimid (lenalidomide) may be approved when all of the following criteria are met **(a., b., and c.)**:
   - **a.** The member is 18 years of age or older.
   - **b.** The member has a diagnosis of multiple myeloma (ICD-10 C90.0).
   - **c.** The member meets one (1) of the following criteria **(i. or ii.)**:
     - **i.** The member is using Revlimid in combination with dexamethasone.
     - **ii.** The member is using Revlimid after autologous hematopoietic stem cell transplantation.

2. **Mantle Cell Lymphoma**
   When a benefit, coverage of Revlimid (lenalidomide) may be approved when all of the following criteria are met **(a., b., and c.)**:
   - **a.** The member is 18 years of age or older.
   - **b.** The member has a diagnosis of mantle cell lymphoma (ICD-10 C83.1).
   - **c.** Disease has relapsed or progressed after two prior therapies, one of which included bortezomib.

3. **Myelodysplastic Syndromes (MDS)**
   When a benefit, coverage of Revlimid (lenalidomide) may be approved when all of the following criteria are met **(a., b., and c.)**:
   - **a.** The member is 18 years of age or older.
   - **b.** The member has a diagnosis of myelodysplastic syndromes (MDS) with a 5-q deletion (ICD-10 D46).
   - **c.** The member meets one (1) of the following **(i. or ii.)**:
     - **i.** The member has transfusion-dependent anemia.
     - **ii.** The member has anemia with documented hemoglobin of less than 10 g/dL.

4. **Follicular Lymphoma**
   When a benefit, coverage of Revlimid (lenalidomide) may be approved when all of the following criteria are met **(a., b., and c.)**:
   - **a.** The member is 18 years of age or older.
   - **b.** The member has a diagnosis of follicular lymphoma (ICD-10 C82.9).
   - **c.** The member is using Revlimid in combination with a rituximab product.

5. **Marginal Zone Lymphoma**
   When a benefit, coverage of Revlimid (lenalidomide) may be approved when all of the following criteria are met **(a., b., and c.)**:
   - **a.** The member is 18 years of age or older.
   - **b.** The member has a diagnosis of marginal zone lymphoma (ICD-10 C88).
   - **c.** The member is using Revlimid in combination with a rituximab product.

C. Pomalyst

1. **Multiple Myeloma**
   When a benefit, coverage of Pomalyst may be approved when all of the following criteria are met **(a. through d.)**:
   - **a.** The member is 18 years of age or older.
   - **b.** The member has a diagnosis of multiple myeloma (ICD-10 C90.0).
   - **c.** The member has received at least two (2) prior therapies, including lenalidomide and a proteasome inhibitor.
   - **d.** The member has progressed on or within 60 days of the last therapy.

2. **Kaposi sarcoma (KS) AIDS-related**
   When a benefit, coverage of Pomalyst may be approved when all of the following criteria are met **(a., b., and c.):**

a. The member is 18 years of age or older.
b. The member has a diagnosis of AIDS-related Kaposi sarcoma (ICD-10 C46.9).
c. The member has been treated with and has failed treatment with highly active antiretroviral therapy (HAART).

3. Kaposi sarcoma (KS); HIV-negative
When a benefit, coverage of Pomalyst (pomalidomide) may be approved when all of the following criteria are met **(a., b., and c.):**
a. The member is 18 years of age or older.
b. The member has a diagnosis of Kaposi sarcoma (ICD-10 C46.9).
c. The member is HIV-negative.

D. Farydak
When a benefit, coverage of Farydak may be approved when all of the following criteria are met **(1., 2., and 3.)**:
1. The member has a diagnosis of multiple myeloma (ICD-10 C90.0).
2. The member using Farydak in combination with bortezomib and dexamethasone.
3. The member has received at least two prior regimens, including bortezomib and an immunomodulatory agent.

II. Reauthorization
When a benefit, reauthorization may be approved when the following criterion is met **(A.)**:
A. The prescriber attests that the member is tolerating therapy and has experienced a therapeutic response defined as either one of the following **(1. or 2.)**:
1. Disease improvement
2. Delayed disease progression

III. An exception to some or all of the criteria above may be granted for select members and/or circumstances based on state and/or federal regulations.

IV. Coverage of oncology medications listed in this policy may be approved on a case-by-case basis per indications supported in the most current NCCN guidelines.

Limitations of Coverage

I. Coverage of drug(s) addressed in this policy for disease states outside of the FDA-approved indications should be denied based on the lack of clinical data to support effectiveness and safety in other conditions unless otherwise noted in the approval criteria.
II. For Commercial or HCR members with a closed formulary, a non-formulary product will only be approved if the member meets the criteria for a formulary exception in addition to the criteria outlined within this policy.

Authorization Duration

- Commercial and HCR Plans: If approved, up to a 12 month authorization may be granted.

Automatic Approval Criteria

None

References:

1. Thalomid [package insert]. Summit, NJ: Celgene Corporation; March 2023.
2. Revlimid [package insert]. Summit, NJ: Celgene Corporation; March 2023.

3. Pomalyst [package insert]. Summit, NJ: Celgene Corporation; March 2023.
4. Farydak [package insert]. East Hanover, NJ: Novartis; July 2021.