Pharmacy Policy Bulletin: J-0900 Proteasome Inhibitors – Commercial and Healthcare Reform	
Number: J-0900	**Category:** Prior Authorization
Line(s) of Business: ☒ Commercial ☒ Healthcare Reform ☐ Medicare	**Benefit(s):** **Commercial:** **Prior Authorization (1.)** 1. Miscellaneous Specialty Drugs Oral = Yes with Prior Authorization **Healthcare Reform:** Not Applicable
Region(s): ☒ All ☐ Delaware ☐ New York ☐ Pennsylvania ☐ West Virginia	**Additional Restriction(s):** None
Version: J-0900-008	**Original Date:** 06/04/2003
Effective Date: 04/25/2025	**Review Date:** 04/09/2025

Drugs Product(s):	• Ninlaro (ixazomib)
FDA-Approved Indication(s):	• Ninlaro ○ In combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received at least one prior therapy.

Background:	• Ninlaro is a reversible proteasome inhibitor that binds to the beta 5 subunit of the 20S proteasome, inducing cell apoptosis of multiple myeloma cell lines. The combination of lenalidomide and Ninlaro demonstrated synergistic cytotoxic effects in multiple myeloma cell lines. • Ninlaro has demonstrated cytotoxicity against myeloma cells in patients who had relapsed after multiple prior therapies, including bortezomib, lenalidomide, and dexamethasone. • Prescribing Considerations ○ Proteasome inhibitors should be prescribed under the supervision of a hematologist/oncologist. ○ Ninlaro is not recommended for use in the maintenance setting or in newly diagnosed multiple myeloma in combination with lenalidomide and dexamethasone outside of controlled clinical trials. ○ Stevens-Johnson syndrome and toxic epidermal necrolysis, including fatal cases, have been reported with Ninlaro. If Stevens-Johnson syndrome or toxic epidermal necrolysis occurs, discontinue Ninlaro and manage as clinically indicated.

Approval Criteria

I. Initial Authorization

When a benefit, coverage of Ninlaro may be approved when all of the following criteria are met **(A., B., and C.)**:

A. The member has a diagnosis of multiple myeloma (ICD10: C90.00, C90.01, C90.02).

B. The member has received at least one (1) prior therapy for multiple myeloma.
C. The member is using Ninlaro in combination with lenalidomide and dexamethasone.

II. Reauthorization:
When a benefit, reauthorization of Ninlaro 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 (1) 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 their 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

For previous versions please see J-0699.

References:

1. Ninlaro [package insert]. Lexington, MA: Takeda Pharmaceuticals America, Inc.; July 2024.