Clinical Policy: Ixazomib (Ninlaro)

Reference Number: CP.PHAR.302
Effective Date: 02.01.17
Last Review Date: 08.21
Line of Business: Commercial, HIM, Medicaid

Revision Log

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

Description

Ixazomib (Ninlaro®) is a proteasome inhibitor.

FDA Approved Indication(s)

Ninlaro is indicated in combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma (MM) who have received at least one prior 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 Ninlaro 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 ≥ 18 years;
4. Prescribed in one of the following ways (a, b, or c):
   a. Subsequent therapy as a single agent for transplant candidates;
   b. As a single agent after prior autologous stem cell transplant;
   c. In combination with dexamethasone with or without either Revlimid®, Pomalyst®, or cyclophosphamide;*

   **Prior authorization may be required for Revlimid, Pomalyst, or cyclophosphamide.*
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 4 mg (1 tablet) per week for 3 weeks of a 28-day (4-week) treatment cycle;
   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/HIM – 6 months
Commercial – Length of Benefit

B. Systemic Light Chain Amyloidosis (off-label) (must meet all)**:**

1. Diagnosis of relapsed or refractory systemic light chain amyloidosis;
2. Prescribed by or in consultation with an oncologist or hematologist;

3. Age ≥ 18 years;
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/HIM – 6 months
Commercial – Length of Benefit

C. Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma (off-label) (must meet all)**:**

1. Diagnosis of Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Prescribed in combination with Rituxan®* and dexamethasone;
   **Prior authorization may be required for Rituxan.*
5. 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/HIM – 6 months
Commercial – Length of Benefit

D. 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.PA.154 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 Ninlaro 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 4 mg (1 tablet) per week for 3 weeks of a 28-day (4-week) treatment cycle;
   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/HIM – 12 months
Commercial – Length of Benefit

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.PA.154 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.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
MM: multiple myeloma
NCCN: National Comprehensive Cancer Network

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MM	4 mg PO on Days 1, 8, and 15 of a 28-day cycle. See Ninlaro Prescription Information for Revlimid and dexamethasone dosing.	4 mg/week

VI. Product Availability

Capsules: 2.3 mg, 3 mg, 4 mg

VII. References

1. Ninlaro Prescribing Information. Cambridge, MA: Millennium Pharmaceuticals, Inc.; March 2021. Available at https://www.ninlaro.com/prescribing-information.pdf. Accessed April 2, 2021.
2. National Comprehensive Cancer Network Drug and Biologics Compendium. Available at www.nccn.org. Accessed April 2, 2021.
3. National Comprehensive Cancer Network. Multiple Myeloma Version 5.2021. Available at nccn.org. Accessed April 2, 2021.
4. National Comprehensive Cancer Network. Systemic Light Chain Amyloidosis Version 2.2021. Available at nccn.org. Accessed April 2, 2021.

5. National Comprehensive Cancer Network. Waldenstrom Macroglobulinemia / Lymphoplasmacytic Lymphoma Version 1.2021. Available at nccn.org. Accessed April 2, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	01.17	02.17
Policy converted to new template. Annual Review. Safety criteria was applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs. Authorization limits extended from 3 and 6 months to 6 and 12 months for initial and continued approval, respectively.	08.17	11.17
3Q 2018 annual review: policies combined for Commercial, HIM (new), and Medicaid lines of business; MM off-label uses added as subsequent therapy in combination with dexamethasone and Pomalyst and as primary therapy in combination with dexamethasone and Revlimid; NCCN and FDA-approved uses summarized for improved clarity (prior chemotherapy requirement removed given new off-label uses); references reviewed and updated.	05.08.18	08.18
3Q 2019 annual review: NCCN recommended off-label use added for systemic light chain amyloidosis; references reviewed and updated.	05.14.19	08.19
3Q 2020 annual review: NCCN recommended uses for MM and Waldenstrom added; references reviewed and updated.	05.12.20	08.20
3Q 2021 annual review: no significant changes; updated reference for HIM off-label use to HIM.PA.154 (replaces HIM.PHAR.21); references reviewed and updated.	04.02.21	08.21

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.