Drug Policy:
Beleodaq™ (belinosat)

I. PURPOSE
To define and describe the accepted indications for Beleodaq (belinosat) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

New Century Health (NCH) is responsible for processing all medication requests from network ordering providers. Medications not authorized by NCH may be deemed as not approvable and therefore not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

II. INDICATIONS FOR USE/INCLUSION CRITERIA
A. PREFERRED MEDICATION GUIDANCE FOR INITIAL REQUEST:
1. When health plan Medicaid coverage provisions—including any applicable PDLs (Preferred Drug Lists)—conflict with the coverage provisions in this drug policy, health plan Medicaid coverage provisions take precedence per the Preferred Drug Guidelines OR
2. When health plan Exchange coverage provisions—including any applicable PDLs (Preferred Drug Lists)—conflict with the coverage provisions in this drug policy, health plan Exchange coverage provisions take precedence per the Preferred Drug Guidelines OR
3. For Health Plans that utilize NCH UM Oncology Clinical Policies as the initial clinical criteria, the Preferred Drug Guidelines shall follow NCH L1 Pathways when applicable, otherwise shall follow NCH drug policies AND
4. Continuation requests of previously approved, non-preferred medication are not subject to this provision AND
5. When available, generic alternatives are preferred over brand-name drugs.

**B. T-cell Lymphomas**

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>DETAILS</th>
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<tbody>
<tr>
<td>CD30+ T-cell lymphoproliferative disorders, including cutaneous ALC Lymphoma</td>
<td>As a single agent for relapsed/refractory disease</td>
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<tr>
<td>Mycosis Fungoides/Sezary Syndrome</td>
<td>As a single agent for relapsed/refractory disease, with or without skin-directed therapy, e.g. ECP: Extra Corporeal Photopheresis As a single agent for first line therapy with or without radiation for local control</td>
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<tr>
<td>Hepatosplenic Gamma-Delta T-cell lymphoma</td>
<td>As a single agent for relapsed/refractory disease</td>
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<tr>
<td>Peripheral T-cell Lymphomas</td>
<td>As a single agent for relapsed/refractory disease</td>
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<tr>
<td>Extra nodal NK/T-cell Lymphoma Nasal Type</td>
<td>As a single agent for relapsed/refractory disease</td>
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**III. EXCLUSION CRITERIA**

A. Disease progression while taking Beleodaq (belinosat) or prior HDAC inhibitor therapy (i.e. romidepsin).

B. Concurrent use with other chemotherapy.

C. Dosing exceeds single dose limit of Beleodaq (belinosat) 1,000 mg/m².

D. Indications not supported by CMS recognized compendia or acceptable peer reviewed literature.

**IV. MEDICATION MANAGEMENT**

A. Please refer to the FDA label/package insert for details regarding these topics.

**V. APPROVAL AUTHORITY**

A. Review – Utilization Management Department

B. Final Approval – Utilization Management Committee

**VI. ATTACHMENTS**

A. None

**VII. REFERENCES**