Drug Policy:
Kyprolis™ (carfilzomib)

I. PURPOSE

To define and describe the accepted indications for Kyprolis (carfilzomib) 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. Multiple Myeloma (MM)

1. NOTE: Per NCH policy and pathway, the preferred Proteasome inhibitor is Velcade (bortezomib) over Kyprolis (carfilzomib) or Ninlaro (ixazomib) for first line therapy of newly diagnosed disease and first line therapy for myeloma in first relapse, unless there is a contraindication/intolerance/disease progression on Velcade (bortezomib)-based therapy. Please refer to UM ONC_1136 Velcade (bortezomib) policy.

2. NOTE: For initial therapy of newly diagnosed multiple myeloma, both transplant eligible and transplant ineligible, Kyprolis (carfilzomib) based regimens are non-preferred per NCH Pathway & NCH Policy: Please refer to the NCH Pathway document for preferred/Level 1 recommended therapies for the initial treatment of Multiple Myeloma.

3. For relapsed or refractory disease, Kyprolis (carfilzomib) may be used for members who have had prior progression on Velcade (bortezomib)-based therapy, with ANY of the following:
   a. In combination with dexamethasone OR
   b. In combination with dexamethasone and lenalidomide OR
   c. In combination with dexamethasone and cyclophosphamide
   d. In combination with daratumumab +/- dexamethasone if the member has not received prior therapy with daratumumab.

III. EXCLUSION CRITERIA

A. Member has disease progression while taking Kyprolis (carfilzomib).

B. Dosing exceeds single dose limit of Kyprolis (carfilzomib) 56 mg/m² twice weekly or 70 mg/m² once weekly.

C. 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


