

Drug Policy:

Beleodaq™ (belinostat)

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| POLICY NUMBER UM ONC_1260 | SUBJECT Beleodaq™ (belinostat) | DEPT/PROGRAM UM Dept | PAGE 1 OF 3 |
| DATES COMMITTEE REVIEWED 11/12/14, 12/18/15, 12/21/16, 11/08/17, 10/10/18, 10/09/19, 12/11/19, 04/08/20, 02/10/21, 11/15/21, 01/12/22, 05/11/22, 08/10/22, 01/11/23, 01/10/24, 01/08/25 | APPROVAL DATE January 08, 2025 | EFFECTIVE DATE January 31, 2025 | COMMITTEE APPROVAL DATES 11/12/14, 12/18/15, 12/21/16, 11/08/17, 10/10/18, 10/09/19, 12/11/19, 04/08/20, 02/10/21, 11/15/21, 01/12/22, 05/11/22, 08/10/22, 01/11/23, 01/10/24, 01/08/25 |
| PRIMARY BUSINESS OWNER: UM | | COMMITTEE/BOARD APPROVAL Evolent Specialty Services Clinical Guideline Review Committee | |
| NCQA STANDARDS UM 2 | | ADDITIONAL AREAS OF IMPACT | |
| CMS REQUIREMENTS | STATE/FEDERAL REQUIREMENTS | APPLICABLE LINES OF BUSINESS Commercial, Exchange, Medicaid | |

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses clinical guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. A list of codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this clinical guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their plan customer service representative for specific coverage information.

I. PURPOSE

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

Evolent is responsible for processing all medication requests from network ordering providers. Medications not authorized by Evolent 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. Continuation requests for a not-approvable medication shall be exempt from this Evolent policy provided:

1. The member has not experienced disease progression on the requested medication **AND**
2. The requested medication was used within the last year without a lapse of more than 30 days of having an active authorization **AND**
3. Additional medication(s) are not being added to the continuation request.

B. T-cell Lymphomas

| DIAGNOSIS | DETAILS OF POLICY-SUPPORTED USE |
|---|---|
| Hepatosplenic Gamma-Delta T-cell lymphoma | As a single agent for relapsed/refractory disease |
| Peripheral T-cell Lymphomas | As a single agent for relapsed/refractory disease |
| Extra nodal NK/T-cell Lymphoma Nasal Type | As a single agent for relapsed/refractory disease |

III. EXCLUSION CRITERIA

- A. Disease progression while taking Beleodaq (belinostat) or on prior HDAC inhibitor therapy [i.e., Istodax (romidepsin)].
- B. Concurrent use with other chemotherapy.
- C. Dosing exceeds single dose limit of Beleodaq (belinostat) 1,000 mg/m².
- D. Investigational use of Beleodaq (belinostat) with an off-label indication that is not sufficient in evidence or is not generally accepted by the medical community. Sufficient evidence that is not supported by CMS recognized compendia or acceptable peer reviewed literature is defined as any of the following:
 1. Whether the clinical characteristics of the patient and the cancer are adequately represented in the published evidence.
 2. Whether the administered chemotherapy/biologic therapy/immune therapy/targeted therapy/other oncologic therapy regimen is adequately represented in the published evidence.
 3. Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients. Generally, the definition of Clinically Meaningful outcomes are those recommended by ASCO, e.g., Hazard Ratio of less than 0.80 and the recommended survival benefit for OS and PFS should be at least 3 months.
 4. Whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover).
 5. That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs.
 6. That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
 7. That abstracts (including meeting abstracts) without the full article from the approved peer-reviewed journals lack supporting clinical evidence for determining accepted uses of drugs.

IV. CODING INFORMATION

| HCPCS Code | Description |
|------------|------------------------------|
| J9032 | Injection, belinostat, 10 mg |

V. MEDICATION MANAGEMENT

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

VI. APPROVAL AUTHORITY

- A. Review – Utilization Management Department
B. Final Approval – Utilization Management Committee

VII. ATTACHMENTS

- A. None

VIII. REFERENCES

- A. Lee HZ, et al. Belinostat for the Treatment of Patients with Relapsed or Refractory Peripheral T-cell Lymphoma. Clin Cancer Res. 2015 Jun 15;21(12):2666-70.
- B. Beleodaq prescribing information 2024. Acrotech Biopharma LLC East Windsor, NJ
- C. Clinical Pharmacology Elsevier Gold Standard 2025.
- D. Micromedex® Healthcare Series: Thomson Micromedex, Greenwood Village, CO 2025.
- E. National Comprehensive Cancer Network. Cancer Guidelines and Drugs and Biologics Compendium 2025.
- F. AHFS Drug Information. American Society of Health-Systems Pharmacists or Wolters Kluwer Lexi-Drugs Bethesda, MD 2025.
- G. Ellis LM, et al. American Society of Clinical Oncology perspective: Raising the bar for clinical trials by defining clinically meaningful outcomes. J Clin Oncol. 2014 Apr 20;32(12):1277-80.
- H. Current and Resolved Drug Shortages and Discontinuations Reported to the FDA:
<http://www.accessdata.fda.gov/scripts/drugshortages/default.cfm>.