Pharmacy Policy

Lymphoma and Leukemia Agents – Unified Formulary

Policy Number: 9.713
Version Number: 1
Version Effective Date: 1/1/2021

Product Applicability	☐ **All Plan+ Products**
Well Sense Health Plan	**Boston Medical Center HealthNet Plan**
☐ New Hampshire Medicaid	☒ MassHealth- MCO ☒ MassHealth- ACO ☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Prior Authorization Policy

Reference Table:

Drugs that require PA	No PA
Aliqopa® (copanlisib)	There are therapeutic alternatives recommended by the NCCN guidelines are used in the treatment of AML, cGVHD, CLL, FL, MCL, MZL, SLL, and WM
Brukinsa® (zanubrutinib)	
Calquence® (acalabrutinib)	
Copiktra® (duvelisib)	
Imbruvica® (ibrutinib)	
Venclexta® (venetoclax)	
Zydelig® (idelalisib)	

cGVHD=chronic graft versus host disease, CLL=chronic lymphocytic leukemia, FL=follicular lymphoma, MCL=mantle cell lymphoma, MZL=marginal zone lymphoma, NCCN=National Comprehensive Cancer Network, SLL=small lymphocytic lymphoma, WM= Waldenström's macroglobulinemia, AML= Acute myeloid leukemia

Procedure:

Approval Diagnosis:	• Acute myeloid leukemia (Venclexta® [venetoclax]) • Chronic graft versus host disease (cGVHD) (Imbruvica® [ibrutinib])

+ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

	• Chronic lymphocytic leukemia (CLL) (Calquence® **[**acalabrutinib], Copiktra® [duvelisib], , Imbruvica® [ibrutinib], Zydelig® [idelalisib]) • Follicular lymphoma (FL) (Aliqopa® [copanlisib], Zydelig® [idelalisib]) • Mantle cell lymphoma (MCL) (Brukinsa® [zanubrutinib], Calquence® [acalabrutinib], Imbruvica® [ibrutinib]) • Marginal zone lymphoma (MZL) (Imbruvica® [ibrutinib]) • Small lymphocytic lymphoma (SLL) (Calquence® **[**acalabrutinib], Copiktra® [duvelisib], Imbruvica® [ibrutinib], Zydelig® [idelalisib]) • Waldenström's macroglobulinemia (WM) (Imbruvica® [ibrutinib])
Approval Criteria: **Aliqopa®** (copanlisib) *FL*	Prescriber provides documentation of **ALL** of the following: 1. Diagnosis of FL 2. Member ≥18 years of age 3. Prescriber is an oncologist or hematologist 4. Appropriate dosing *5.* Prior therapy for the treatment of FL with at least two systemic therapies *(History of claims is sufficient; See Appendix III for appropriate therapy)*
Approval Criteria: **Brukinsa®** (zanubrutinib) *MCL*	Prescriber provides documentation of **ALL** of the following: 1. Appropriate diagnosis 2. Member ≥18 years of age 3. Prescriber is an oncologist or hematologist 4. Appropriate dosing *5.* Prior therapy for the treatment of MCL *(History of claims is sufficient; See Appendix I for appropriate prior therapy)*
Approval Criteria: **Calquence®** (acalabrutinib) *CLL/SLL*	Prescriber provides documentation of **ALL** of the following: 1. Appropriate diagnosis 2. Member ≥18 years of age 3. Prescriber is an oncologist or hematologist 4. Appropriate dosing 5. **ONE** of the following: a. Member is treatment naive **AND ONE** of the following: a. Requested agent will be used in combination with Gazyva® (obinutuzumab) b. Clinical rationale for use of the requested agent as monotherapy *b.* Member has relapsed or refractory disease OR prior therapy for the treatment of CLL/SLL *(History of claims is sufficient; See Appendix II for appropriate prior therapy)*
Approval Criteria: **Calquence®** (acalabrutinib) *MCL*	Prescriber provides documentation of **ALL** of the following: 1. Appropriate diagnosis 2. Member ≥18 years of age 3. Prescriber is an oncologist or hematologist 4. Appropriate dosing *5.* Prior therapy for the treatment of MCL *(History of claims is sufficient; See Appendix I for appropriate prior therapy)*
Approval Criteria:	Prescriber provides documentation of **ALL** of the following: 1. Appropriate diagnosis

Copiktra® (duvelisib) *CLL/SLL (relapsed or refractory)*	2. Member is ≥18 years of age 3. Prescriber is an oncologist or hematologist 4. Appropriate dosing 5. Prior therapy for the treatment of CLL/SLL with at least two prior therapies* (*History of claims is sufficient; See Appendix II for appropriate prior therapy*) *Notes:* • **Radiation therapy can be counted as one prior therapy*
Approval Criteria: **Copiktra**® (duvelisib) *FL (relapsed or refractory)*	Prescriber provides documentation of **ALL** of the following: 1. Appropriate diagnosis 2. Member is ≥18 years of age 3. Prescriber is an oncologist or hematologist 4. Appropriate dosing 5. Prior therapy for the treatment of FL with at least two prior systemic therapies (*history of claims is sufficient, See Appendix III for appropriate prior therapy*) *Notes:* • *Although claims history count for the trial requirement, the Smart PA rule is not coded to look for these trials. Please manually review claims history for preferred trials.*
Approval Criteria: **Imbruvica**® (ibrutinib) *cGVHD*	Prescriber provides documentation of **ALL** of the following: 1. Diagnosis of cGVHD 2. Member ≥18 years of age 3. Appropriate dosing 4. Prescriber is an oncologist or hematologist 5. Prior therapy for the treatment of cGVHD with at least one systemic therapy *(History of claims is sufficient; See Appendix IV for appropriate prior therapy)* *Notes:* • *Although claims history count for the trial requirement, the Smart PA rule is not coded to look for these trials. Please manually review claims history for preferred trials.*
Approval Criteria: **Imbruvica**® (ibrutinib) *CLL/SLL, CLL/SLL with 17p deletion, and WM*	Prescriber provides documentation of **ALL** of the following: 1. Diagnosis of CLL/SLL, CLL/SLL with 17p deletion, or WM 2. Member ≥18 years of age 3. Appropriate dosing 4. Prescriber is an oncologist or hematologist
Approval Criteria: **Imbruvica**® (ibrutinib) *MCL, MZL*	Prescriber provides documentation of **ALL** of the following: 1. Diagnosis of MCL or MZL 2. Member ≥18 years of age 3. Appropriate dosing 4. Prescriber is an oncologist or hematologist 5. Prior therapy for the treatment of MCL or MZL with at least one

	systemic therapy *(History of claims is sufficient; See Appendix I and V for appropriate prior therapy)* *Notes:* • *Although claims history count for the trial requirement, the Smart PA rule is not coded to look for these trials. Please manually review claims history for preferred trials.*
Approval Criteria: **Venclexta®** (venetoclax) *AML*	Prescriber provides documentation of **ALL** of the following: 1. Diagnosis of AML 2. Prescriber is an oncologist or hematologist 3. Appropriate dosing 4. **ONE** of the following: a. Age ≥60 years b. Clinical rationale for use of requested agent instead of intensive induction chemotherapy 5. Requested agent will be used in combination with azacitidine, decitabine, or low-dose cytarabine
Approval Criteria: **Venclexta®** (venetoclax) *CLL, SLL*	Prescriber provides documentation of **ALL** of the following: 1. Diagnosis of CLL or SLL 2. Member ≥18 years of age 3. Prescriber is an oncologist or hematologist 4. Appropriate dosing 5. **ONE** of the following a. Member has not received treatment for CLL or SLL **AND BOTH** of the following: 1. Requested agent will be used in combination with Gazyva® (obinutuzumab) 2. Clinical rationale for use of the requested agent instead of Imbruvica® (ibrutinib) b. Prior therapy for the treatment of CLL or SLL with at least one systemic therapy *(History of claims is sufficient; See Appendix II for appropriate prior therapy)* **AND** requested agent will be used in combination with Rituxan® (rituximab)** *Note:* • *Although claims history counts for the trial requirement, the Smart PA rule is not coded to look for these trials. Please manually review claims history for preferred trials.* • ***The FDA-labeling for Venclexta® (venetoclax) does not specify combination therapy or monotherapy. According to the NCCN guidelines for the treatment of CLL/SLL, Venclexta® (venetoclax) + Rituxan® (rituximab) is a preferred (category 1) regimen for relapsed/refractory disease with and without del(17p)/TP53 mutation and Venclexta® (venetoclax) monotherapy is listed under other recommended regimens (category 2A) for relapsed/refractory disease without del(17p)/TP53 mutation and under preferred (category 2A) for relapsed/refractory disease with del(17p)/TP53 mutation.*

Approval Criteria: **Zydelig®** (idelalisib) *CLL*	Prescriber provides documentation of **ALL** of the following: 1. Diagnosis of CLL 2. Member ≥18 years of age 3. Prescriber is an oncologist or hematologist 4. Appropriate dosing 5. **ONE** of the following: a. Relapsed or refractory CLL b. Prior therapy for the treatment of CLL with at least one systemic therapy *(History of claims is sufficient; See Appendix II for appropriate prior therapy)* 6. Inadequate response, adverse reaction or contraindication to Imbruvica® (ibrutinib) *(History of claims is sufficient)* *Notes:* • *Although claims history count for the trial requirement, the Smart PA rule is not coded to look for these trials. Please manually review claims history for preferred trials.*
Approval Criteria: **Zydelig®** (idelalisib) *FL*	Prescriber provides documentation of **ALL** of the following: 1. Diagnosis of FL 2. Member ≥18 years of age 3. Prescriber is an oncologist or hematologist 4. Appropriate dosing 5. Prior therapy for the treatment of FL with at least two systemic therapies *(History of claims is sufficient; See Appendix III for appropriate prior therapy)* *Notes:* • *Although claims history count for the trial requirement, the Smart PA rule is not coded to look for these trials. Please manually review claims history for preferred trials.*
Approval Criteria: **Zydelig®** (idelalisib) *SLL*	Prescriber provides documentation of **ALL** of the following: 1. Diagnosis of SLL 2. Member ≥18 years of age 3. Prescriber is an oncologist or hematologist 4. Appropriate dosing 5. Prior therapy for the treatment of SLL with at least two systemic therapies *(History of claims is sufficient; See Appendix II for appropriate prior therapy)* *Notes:* • *Although claims history count for the trial requirement, the Smart PA rule is not coded to look for these trials. Please manually review claims history for preferred trials.*
Denial Criteria:	Cases that do not meet the approval criteria will be denied.
	If a request is denied and the prescriber has additional clinical documentation, a **new** prior authorization request must be submitted.
Duration/Quantity of	Prior authorization may be issued for **6 months.**

Authorization:	
Recertification Criteria:	Resubmission by prescriber will infer a positive response to therapy and request can be recertified for **up to 6 months.**

Appendix:

Stability

Stability alone on Burkinsa® (zanubrutinib), Calquence® (acalabrutinib), Copiktra® (duvelisib), Imbruvica® (ibrutinib), Venclexta® (venetoclax), and Zydelig® (idelalisib) is not a reason to bypass approval criteria. However, requests for members who have already started treatment on these agents should be reviewed with clinical review and approval strongly considered for any member with any FDA-approved indication.

Grandfathering

Information is not applicable.

Additional Information

Appendix I: First-line induction therapy for MCL

The NCCN Guidelines for the treatment of B-Cell Lymphomas (section on MCL) note that first-line therapy for patients with MCL is radiation therapy alone or radiation therapy in combination with chemo-immunotherapy. Examples of acceptable induction chemo-immunotherapy regimens (both aggressive and less aggressive) are listed below. Please note this list is **not** all inclusive.

a. Rituximab, dexamethasone, and cytarabine (RDHA) plus platinum (cisplatin, carboplatin, or oxaliplatin)
b. Alternating RCHOP and rituximab, dexamethasone, cisplatin and cytarabine (RDHAP)
c. Rituximab plus cyclophosphamide, vincristine, doxorubicin, and prednisone (maxi-CHOP) alternating with rituximab plus high dose cytarabine (NORDIC regimen)
d. Cyclophosphamide, vincristine, doxorubicin and dexamethasone alternating with high-dose methotrexate and cytarabine (HyperCVAD) and rituximab
e. Bendamustine and rituximab
f. Bortezomib, rituximab, cyclophosphamide, doxorubicin, and prednisone (VR-CAP)
g. Rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone (RCHOP)
h. Lenalidomide plus rituximab
i. Modified HyperCVAD and rituximab
    - o

Members may receive other lines of therapy not indicated in the latest update of the NCCN guidelines.

Appendix II: First-line chemo-immunotherapy for CLL/SLL

Examples of acceptable chemo-immunotherapy regimens recommended by the NCCN guidelines are listed below. Please note this list is not all inclusive.

First-line treatment options for CLL/SLL (without del[17p]/TP53 mutation) include:

a. Imbruvica® (ibrutinib) monotherapy
b. Venclexta® (venetoclax) plus Gazyva® (obinutuzumab)

c. Calquence® (acalabrutinib) with or without Gazyva® (obinutuzumab)
d. Bendamustine plus an anti-CD20 monoclonal antibody
e. Leukeran® (chlorambucil) plus Gazyva® (obinutuzumab)
f. High-dose methylprednisolone plus rituximab
g. Imbruvica® (ibrutinib) plus Gazyva® (obinutuzumab)
h. Gazyva® (obinutuzumab) monotherapy
i. Leukeran® (chlorambucil) monotherapy
j. Rituximab monotherapy

First-line treatment options for CLL/SLL (with del[17p]/TP53 mutation) include:
a. Imbruvica® (ibrutinib) monotherapy
b. Calquence® (acalabrutinib) with or without Gazyva® (obinutuzumab)
c. Venclexta® (venetoclax) plus Gazyva® (obinutuzumab)
d. Alemtuzumab with or without rituximab
e. High-dose methylprednisolone plus rituximab
f. Gazyva® (obinutuzumab) monotherapy

Appendix III: First-line chemo-immunotherapy for FL

Examples of acceptable chemo-immunotherapy regimens recommended by the NCCN guidelines are listed below. Please note this list is not all inclusive.

First-line treatment options for FL include:
a. Radioimmunotherapy
b. Bendamustine plus obinutuzumab or rituximab
c. Cyclophosphamide, doxorubicin, vincristine, prednisone (CHOP) plus obinutuzumab or rituximab
d. Cyclophosphamide, vincristine, prednisone (CVP) plus obinutuzumab or rituximab
e. Lenalidomide plus rituximab or obinutuzumab
f. Rituximab monotherapy

Appendix IV: Systemic Therapies for Chronic Graft-versus-Host Disease

Treatment is not clearly defined for cGVHD but often includes use of corticosteroids. In treating resistant disease, the following may be used (however, data is mixed):
a. Calcineurin inhibitors (cyclosporine, tacrolimus)
b. Mycophenolate mofetil
c. Sirolimus
d. Ruxolitinib
e. Rituximab
f. Tyrosine kinase inhibitors (imatinib)
g. Ursodeoxycholic acid
h. Interleukin-2 may be used

Appendix V: First- and Second-Line Therapies for Marginal Zone Lymphomas

Examples of acceptable chemo-immunotherapy regimens recommended by the NCCN guidelines are listed below. Please note this list is not all inclusive.

First line treatments for MZL include:

a. Bendamustine plus rituximab
b. RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone)
c. RCVP (rituximab, cyclophosphamide, vincristine, prednisone)
d. Rituximab monotherapy
e. Ibritumomab tiuxetan
f. Lenalidomide plus rituximab
g. Single-agent alkylators with or without rituximab (elderly or infirm patients)

Second-line and subsequent therapy includes ibrutinib, lenalidomide with or without rituximab, bendamustine plus obinutuzumab, copanlisib, duvelisib, and idelalisib, in addition to first-line chemoimmunotherapy.

Clinical Background Information and References

Original Approval Date	Original Effective Date	Policy Owner	Approved by
12/1/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
12/1/2020	New policy created to align with MH Unified Formulary Policy	1/1/2021	P&T Committee

Next Review Date

2021

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered

experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.