

Drug Policy:

Kyprolis™ (carfilzomib)

POLICY NUMBER UM ONC_1224	SUBJECT Kyprolis™ (carfilzomib)	DEPT/PROGRAM UM Dept	PAGE 1 OF 2
DATES COMMITTEE REVIEWED 10/03/12, 12/11/13, 03/11/15, 03/27/15, 05/24/16, 03/04/17, 03/14/18, 03/13/19, 12/11/19, 03/11/20, 04/08/20, 08/12/20	APPROVAL DATE August 12, 2020	EFFECTIVE DATE August 28, 2020	COMMITTEE APPROVAL DATES (latest version listed last) 10/03/12, 12/11/13, 03/11/15, 03/27/15, 05/24/16, 03/04/17, 03/14/18, 03/13/19, 12/11/19, 03/11/20, 04/08/20, 08/12/20
PRIMARY BUSINESS OWNER: UM APPROVED BY: Dr. Andrew Hertler		COMMITTEE/BOARD APPROVAL Utilization Management Committee	
URAC STANDARDS HUM 1	NCQA STANDARDS UM 2	ADDITIONAL AREAS OF IMPACT	
CMS REQUIREMENTS	STATE/FEDERAL REQUIREMENTS	APPLICABLE LINES OF BUSINESS All	

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. Initial Therapy: Please refer to the NCH Pathway document for preferred/Level 1 recommended therapies for the initial treatment of Multiple Myeloma.
2. For relapsed or refractory disease, Kyprolis (carfilzomib) may be used 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.

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

- A. Kyprolis prescribing information. ONYX Pharmaceuticals, Inc. South San Francisco, CA 2019.
- B. Clinical Pharmacology Elsevier Gold Standard. 2020.
- C. Micromedex® Healthcare Series: Thomson Micromedex, Greenwood Village, Co. 2020.
- D. National Comprehensive Cancer Network. Cancer Guidelines and Drugs and Biologics Compendium. 2020.
- E. AHFS Drug Information. American Society of Health-Systems Pharmacists or Wolters Kluwer Lexi-Drugs. Bethesda, MD. 2020.