POLICY Document for DARZALEX (daratumumab)

The overall objective of this policy is to support the appropriate and cost-effective use of the medication, specific to use of preferred medication options, and overall, clinically appropriate use. This document provides specific information to both sections of the overall policy.

Section 1: Clinical Criteria

- Policy information specific to the clinical appropriateness for the medication

Section 2: Oncology Clinical Policy

- Policy information specific to regimen review per NCCN Guidelines.

Section 1: Clinical Criteria

Specialty Guideline Management
Darzalex

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Darzalex	daratumumab

Indications

The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications[1]

Darzalex is indicated for the treatment of adult patients with multiple myeloma:

In combination with lenalidomide and dexamethasone in newly diagnosed patients who are ineligible for autologous stem cell transplant and in patients with relapsed or refractory multiple myeloma who have received at least one prior therapy.
In combination with bortezomib, melphalan and prednisone in newly diagnosed patients who

are ineligible for autologous stem cell transplant.
In combination with bortezomib, thalidomide, and dexamethasone in newly diagnosed patients who are eligible for autologous stem cell transplant.
In combination with bortezomib and dexamethasone in patients who have received at least one prior therapy.
In combination with carfilzomib and dexamethasone in patients with relapsed or refractory multiple myeloma who have received one to three prior lines of therapy.
In combination with pomalidomide and dexamethasone in patients who have received at least two prior therapies including lenalidomide and a proteasome inhibitor.
As monotherapy, in patients who have received at least three prior lines of therapy including a proteasome inhibitor (PI) and an immunomodulatory agent or who are double-refractory to a PI and an immunomodulatory agent.

Compendial Uses[2-4]

Multiple myeloma
Systemic light chain amyloidosis
T-cell acute lymphoblastic leukemia (T-ALL)
POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome
All other indications are considered experimental/investigational and not medically necessary.

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

Documentation of testing or laboratory results confirming t(11:14) translocation, where applicable.

Coverage Criteria

Multiple Myeloma[1-4]

Authorization of 12 months may be granted for the treatment of multiple myeloma when used in combination with cyclophosphamide, bortezomib, and dexamethasone.

Authorization of 12 months may be granted for the treatment of multiple myeloma as primary therapy when any of the following criteria is met:

The member is ineligible for a transplant and the requested medication will be used in combination with either:
Lenalidomide and dexamethasone
Bortezomib, melphalan, and prednisone
The member is eligible for transplant and the requested medication will be used in combination with any of the following:
Bortezomib, thalidomide, and dexamethasone for a maximum of 16 doses

Bortezomib, lenalidomide, and dexamethasone
Carfilzomib, lenalidomide, and dexamethasone
Authorization of 12 months may be granted for the treatment of previously treated multiple myeloma when any of the following criteria is met:

The requested medication will be used in combination with lenalidomide and dexamethasone in members who have received at least one prior therapy
The requested medication will be used in combination with bortezomib and dexamethasone in members who have received at least one prior therapy
The requested medication will be used in combination with carfilzomib and dexamethasone in members who have received at least one prior therapy
The requested medication will be used in combination with carfilzomib, pomalidomide, and dexamethasone
The requested medication will be used in combination with pomalidomide and dexamethasone in members who have received at least one prior therapy including a proteasome inhibitor (PI) and an immunomodulatory agent
The requested medication will be used in combination with selinexor and dexamethasone
The requested medication will be used in combination with venetoclax and dexamethasone for members with documented t(11:14) translocation
The requested medication will be used as a single agent in members who have received at least three prior therapies, including a PI and an immunomodulatory agent
The requested medication will be used as a single agent in members who are double refractory to a PI and an immunomodulatory agent
Authorization of 12 months may be granted for maintenance therapy of symptomatic multiple myeloma for transplant candidates when used in combination with lenalidomide.

POEMS (Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal protein, Skin changes) Syndrome[2,3]

Authorization of 12 months may be granted for the treatment of POEMS syndrome when used in combination with lenalidomide and dexamethasone as induction therapy for transplant eligible member.

Systemic Light Chain Amyloidosis[2,4]

Authorization of 12 months may be granted for the treatment of systemic light chain amyloidosis if either of the following criteria is met:

The requested medication will be used in combination with bortezomib, cyclophosphamide and dexamethasone or as a single agent.

For members with relapsed or refractory disease and the requested medication will be used in combination with lenalidomide and dexamethasone.

T-cell Acute Lymphoblastic Leukemia (T-ALL)[2]

Authorization of 12 months may be granted for the treatment of T-cell acute lymphoblastic leukemia (T-cell) when the member has relapsed or refractory disease and the requested medication will be used in combination with any of the following:

Vincristine, pegaspargase, doxorubicin, and prednisone or dexamethasone
Vincristine, calaspargase, doxorubicin, and prednisone or dexamethasone

Continuation of Therapy

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when either of the following regimen or indication-specific criteria is met:

All members (including new members) requesting the requested medication in combination with bortezomib, thalidomide, and dexamethasone for multiple myeloma must meet all requirements in the coverage criteria section.
For all other regimens and indications listed in the coverage criteria section, there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

Section 2: Oncology Clinical Policy

PURPOSE

The purpose of this policy is to define the Novologix NCCN® Regimen Prior Authorization Program.

SCOPE

This policy applies to clients who have implemented the Novologix NCCN® Program as a part of their medical and/or pharmacy prior authorization solution.

PROGRAM DESCRIPTION

The National Comprehensive Care Network® (NCCN®) is an alliance of leading cancer centers devoted to patient care, research and education dedicated to improving the quality, effectiveness, and efficiency of cancer care so patients can live better lives.[1] It is comprised of oncology experts who convene regularly to establish the best treatments for patients. NCCN develops various resources for use by stakeholders in the health care delivery system. These resources include, but are not limited to, the NCCN Clinical Practice Guidelines in Oncology

(NCCN Guidelines®), the NCCN Drugs & Biologics Compendium (NCCN Compendium®) and the NCCN Chemotherapy Order Templates (NCCN Templates®).

NCCN Templates® are based on NCCN Guidelines® and NCCN Compendium®. The NCCN Compendium lists the appropriate drugs and biologics as treatment options for specific cancers using U.S. Food and Drug Administration (FDA)-approved disease indications and specific NCCN panel recommendations. Each recommendation is supported by a level of evidence category.

NCCN Categories of Evidence and Consensus[2]

- Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
- Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
- Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
- Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

POLICY

Policy for Regimen Prior Authorization

A regimen prior authorization allows submission of a single prior authorization request for all oncology drugs or biologics within an NCCN template that require prior authorization.

PROCEDURE

This policy provides coverage of a regimen review when all of the following criteria are met:

1. Regimen prior authorization reviews, based on NCCN templates, are initiated through the provider portal.
   - If the prior authorization request is submitted via phone or fax, each drug or biologic will need to be submitted and reviewed as a separate prior authorization request for review with drug-specific criteria.
2. The prior authorization review is requested for an oncology drug or biologic.
3. The member is eligible for regimen review.
4. The indication is for a cancer that is eligible for regimen review. Currently, the cancer types in scope for regimen review include the following:
   - Ampullary Adenocarcinoma
   - Anal Carcinoma
   - B-Cell Lymphomas

- Basal Cell Skin Cancer
- Biliary Tract Cancers
- Bone Cancer
- Breast Cancer
- Bladder Cancer
- Central Nervous System Cancers
- Cervical Cancer
- Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
- Chronic Myeloid leukemia
- Colon Cancer
- Dermatofibrosarcoma Protuberans
- Esophageal Cancer
- Gastric Cancer
- Gastrointestinal Stromal Tumors
- Gestational Trophoblastic Neoplasms
- Hairy Cell Leukemia
- Head and Neck Cancers
- Histiocytic Neoplasms
- Hodgkin Lymphoma
- Hepatocellular Carcinoma
- Kaposi Sarcoma
- Kidney Cancer
- Melanoma: Cutaneous
- Melanoma: Uveal
- Merkel Cell Carcinoma
- Mesothelioma: Peritoneal
- Mesothelioma: Pleural
- Multiple Myeloma
- Myelodysplastic Syndromes
- Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions
- Myeloproliferative Neoplasms
- Neuroendocrine and Adrenal Tumors
- Non-Small Cell Lung Cancer
- Occult Primary
- Ovarian Cancer
- Pancreatic Cancer
- Penile Cancer
- Primary Cutaneous Lymphomas
- Prostate Cancer

- Rectal Cancer
- Small Bowl Adenocarcinoma
- Small Cell Lung Cancer
- Soft Tissue Sarcoma
- Squamous Cell Skin Cancer
- Systemic Mastocytosis
- Systemic Light Chain Amyloidosis
- T-Cell Lymphomas
- Testicular Cancer
- Thymomas and Thymic Carcinomas
- Thyroid Carcinoma
- Uterine Neoplasms
- Vaginal Cancer
- Vulvar Cancer
- Waldenström Macroglobulinemia / Lymphoplasmacytic Lymphoma
- Wilms Tumor (Nephroblastoma)

In addition, the following criteria must be met for approval:

1. The requested regimen for the drug(s) or biologic(s) and indication is consistent with an NCCN recommendation with a level of evidence category of 1 or 2A.
2. The NCCN template must be accepted by the provider without modification.

Further review may be indicated when the above criteria are not met.

Authorizations may be granted for 12 months or as medically required, based on the member's condition and provider's assessment.

Supportive Care: Myeloid Growth Factor Therapy

Granulocyte colony stimulating factors are recommended for primary prophylaxis based on the febrile neutropenia risk of the chemotherapy regimen. Febrile neutropenia risk levels vary by NCCN Chemotherapy Order template and are listed at the top of the template. Regimens associated with a high or intermediate risk of febrile neutropenia may include a granulocyte colony stimulating factor as part of the prior authorization.

Continuation of Therapy

To submit a request for continuation of therapy, a new regimen prior authorization review must be requested. Upon template selection, the template must be modified to include the appropriate therapies being used for maintenance treatment. The regimen request will be submitted for further review.

Dosage and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and evidence-based practice guidelines.

REFERENCES:

SECTION 1

1. Darzalex [package insert]. Horsham, PA: Janssen Biotech Inc; July 2024.
2. The NCCN Drugs & Biologics Compendium® ©2024 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed October 1, 2024.
3. The NCCN Clinical Practice Guidelines in Oncology Multiple Myeloma (Version 1.2025) 2024 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed October 2, 2024.
4. IBM Micromedex® DRUGDEX® (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at: https://www.micromedexsolutions.com/ Accessed: October 2, 2024.

SECTION 2

1. National Comprehensive Cancer Network. About NCCN website. https://www.nccn.org/home/about, accessed September 9, 2024.
2. National Comprehensive Cancer Network. NCCN Categories of Evidence and Consensus website, https://www.nccn.org/guidelines/guidelines-process/development-and-update-of-guidelines, accessed September 9, 2024.
3. National Comprehensive Cancer Network. NCCN Guidelines website. https://www.nccn.org/guidelines/category_1, accessed September 9, 2024. (Note: An account may be required.)
4. National Comprehensive Cancer Network. NCCN Drugs and Biologics Compendium website https://www.nccn.org/compendia-templates/compendia/drugs-and-biologics-compendia, accessed September 9, 2024. (Note: A subscription may be required.)
5. National Comprehensive Cancer Network. NCCN Chemotherapy Order Templates (NCCN Templates) website. https://www.nccn.org/compendia-templates/nccn-templates-main/browse-by-cancer-type, accessed September 9, 2024. (Note: A subscription may be required.)