Reference number(s)
4416-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	☐
Standard Control Choice (SCCF)	☐
Preferred Drug Plan Design (PDPD)	☐
Advanced Control Specialty (ACSF)	☐
Advanced Control Specialty Choice (ACSCF)	☐
Managed Medicaid Template (MMT)	☐
Marketplace (MF)	☐
Aetna Small Group Affordable Care Act (SG ACA) Aetna Health Exchange (AHE)	☐
Value (VF)	☐

Formulary	Applies
New to Market (NTM)	☐
Standard Formulary Chart (SFC)	☑
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	☐
Advanced Control Specialty Formulary Chart (ACSFC)	☑
Value Formulary Chart (VFC)	☐
Medical Benefit	☐
Medical Benefit: Advanced Biosimilars First	☐
Combined Benefit Management (CBM)	☐
Combined Benefit Management Pharmacy (CBMP)	☐
Medical Benefit Managed Medicaid (MMMB)	☐

Exceptions Criteria
Multiple Myeloma

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Standard Formulary Chart (SFC) and Advanced Control Specialty Formulary Chart (ACSFC).

Plan Design Summary

This program applies to the multiple myeloma products specified in this document. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred products and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to members who are new to treatment with Kyprolis for the first time. This program applies to all members requesting treatment with branded generic bortezomib.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Multiple Myeloma Therapies

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

	Products
Preferred	• Ninlaro (ixazomib) • Velcade (bortezomib)
Target	• bortezomib (branded generic) • Kyprolis (carfilzomib)

Exception Criteria

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

Coverage for Kyprolis is provided when either of the following criteria is met:

- Member is currently receiving treatment with a targeted product, excluding when the requested targeted product is obtained as samples or via manufacturer's patient assistance programs.
- Member has a documented inadequate response or intolerable adverse event with both of the preferred products.

Coverage for bortezomib (branded generic) is provided when both of the following criteria are met:

- Member has a documented inadequate response or intolerable adverse event with Ninlaro.
- Member has a documented intolerable adverse event to Velcade, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and generic medication).

References

1. Ninlaro [package insert]. Cambridge, MA: Takeda Pharmaceuticals America, Inc.; July 2024.
2. Velcade [package insert]. Cambridge, MA: Takeda Pharmaceuticals America, Inc.; August 2025.
3. bortezomib [package insert]. Lake Zurich, IL: Fresenius Kabi; March 2025.
4. Kyprolis [package insert]. Thousand Oaks, CA: Onyx Pharmaceuticals, Inc.; June 2025.