

Specialty Guideline Management

Beleodaq

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
Beleodaq	belinostat

Indications

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

FDA-approved Indications¹

Treatment of adult patients with relapsed or refractory peripheral T-cell lymphoma (PTCL).

Compendial Uses²

T-Cell Lymphomas

- Hepatosplenic T-cell lymphoma
- Extranodal NK/T-cell lymphoma
- Adult T-cell leukemia/lymphoma (ATLL)
- Breast implant associated anaplastic large cell lymphoma (ALCL)

All other indications are considered experimental/investigational and not medically necessary.

Coverage Criteria

T-Cell Lymphomas^{1,2}

Authorization of 12 months may be granted for treatment T-cell lymphomas with any of the following subtypes:

- Peripheral T-cell lymphoma [including the following subtypes: anaplastic large cell lymphoma, peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with TFH phenotype, or follicular T-cell lymphoma] when both of the following criteria are met:
 - The requested drug will be used as a single agent.
 - The requested drug is used for relapsed or refractory disease or for palliative intent.
- Hepatosplenic T-cell lymphoma when both of the following criteria are met:
 - The requested drug will be used a single agent.
 - The member has had two or more previous lines of chemotherapy.
- Extranodal NK/T-cell lymphoma when all of the following criteria are met:
 - The requested drug will be used as a single agent.
 - The member has relapsed or refractory disease.
 - The member has had an inadequate response or contraindication to asparaginase-based therapy (e.g., pegaspargase).
- Adult T-cell leukemia/lymphoma (ATLL) when both of the following criteria are met:
 - The requested drug is used as a single agent.
 - The requested drug is used for subsequent therapy.
- Breast implant-associated anaplastic large cell lymphoma (ALCL) when both of the following criteria are met:
 - The requested drug is used as a single agent.
 - The requested drug is used for subsequent therapy.

Continuation of Therapy

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication in the coverage criteria section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

References

1. Beleodaq [package insert]. East Windsor, NJ: Acrotech Biopharma Inc.; April 2025.
2. The NCCN Drugs & Biologics Compendium® © 2025 National Comprehensive Cancer Network, Inc. Available at: <https://www.nccn.org> Accessed April 11, 2025.