Clinical Policy: Pomalidomide (Pomalyst)

Reference Number: CP.PHAR.116
Effective Date: 07.01.13
Last Review Date: 05.22
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Pomalidomide (Pomalyst®) is a thalidomide analogue.

FDA Approved Indication(s)

Pomalyst is indicated for the treatment of adult patients:

- In combination with dexamethasone, for patients with multiple myeloma (MM) who have received at least two prior therapies including lenalidomide and a proteasome inhibitor and have demonstrated disease progression on or within 60 days of completion of the last therapy.
- With acquired immunodeficiency syndrome (AIDS)-related Kaposi sarcoma (KS) after failure of highly active antiretroviral therapy (HAART) or in patients with KS who are human immunodeficiency virus (HIV)-negative.*

*This indication is approved under accelerated approval based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Pomalyst is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Multiple Myeloma (must meet all):

1. Diagnosis of MM;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Failure of an immunomodulatory agent (e.g., Revlimid®, Thalomid®) and a proteasome inhibitor (e.g., bortezomib, Kyprolis®, Ninlaro®), unless clinically significant adverse effects are experienced or all are contraindicated;*
   **Prior authorization may be required for immunomodulatory agents and proteasome inhibitors.*
5. For Pomalyst requests, member must use pomalidomide, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Pomalyst is not prescribed concurrently with Revlimid or Thalomid;
7. Request meets one of the following (a or b):*
   a. Dose does not exceed 4 mg (1 capsule) per day on days 1-21 of repeated 28-day cycles;

b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months
Commercial – 12 months or duration of request, whichever is less

B. Kaposi Sarcoma (must meet all)**:**

1. Diagnosis of KS;
2. Prescribed by or in consultation with an oncologist, dermatologist, immunologist, or infectious disease specialist;
3. Age ≥ 18 years;
4. If disease is AIDS-related, Pomalyst is prescribed in combination with antiretroviral therapy;
5. Failure of liposomal doxorubicin and paclitaxel, unless clinically significant adverse effects are experienced or both are contraindicated;
6. For Pomalyst requests, member must use pomalidomide, if available, unless contraindicated or clinically significant adverse effects are experienced;
7. Pomalyst is not prescribed concurrently with Revlimid or Thalomid;
8. Request meets one of the following (a or b):*
   a. Dose does not exceed 5 mg (2 capsules) per day on days 1-21 of repeated 28-day cycles;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months
Commercial – 12 months or duration of request, whichever is less

C. Systemic Light Chain Amyloidosis (off-label) (must meet all)**:**

1. Diagnosis of systemic light chain amyloidosis;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Disease is relapsed or refractory to prior therapy;
5. Prescribed in combination with dexamethasone;
6. For Pomalyst requests, member must use pomalidomide, if available, unless contraindicated or clinically significant adverse effects are experienced;
7. Pomalyst is not prescribed concurrently with Revlimid or Thalomid;
8. Request meets one of the following (a or b):*
   a. Dose does not exceed 4 mg (1 capsule) per day on days 1-21 of repeated 28-day cycles;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months
Commercial – 12 months or duration of request, whichever is less

D. Primary Central Nervous System (CNS) Lymphoma (off-label) (must meet all):
1. Diagnosis of primary CNS lymphoma;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Request is for one of the following (a or b):
   a. Disease is relapsed or refractory to prior therapy;
   b. Induction therapy as a single agent if member is unsuitable for or intolerant to high-dose methotrexate;
5. For Pomalyst requests, member must use pomalidomide, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Pomalyst is not prescribed concurrently with Revlimid or Thalomid;
7. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).*
   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months
Commercial – 12 months or duration of request, whichever is less

E. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (meets all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Pomalyst for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Pomalyst requests, member must use pomalidomide, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. Pomalyst is not prescribed concurrently with Revlimid or Thalomid;

5. If request is for a dose increase, request meets one of the following (a, b, or c):*
   a. For KS only: New dose does not exceed 5 mg (2 capsules) per day on days 1-21 of repeated 28-day cycles;
   b. New dose does not exceed 4 mg (1 capsule) per day on days 1-21 of repeated 28-day cycles;
   c. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AIDS: acquired immunodeficiency syndrome
CNS: central nervous system
FDA: Food and Drug Administration
HAART: highly active antiretroviral therapy
HIV: human immunodeficiency virus
KS: Kaposi sarcoma
MM: multiple myeloma

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Revlimid® (lenalidomide)	*MM* 25 mg PO QD days 1-21 of repeated 28 day cycles.	25 mg/day
Thalomid® (thalidomide)	*MM* 200 mg PO QD.	200 mg/day
bortezomib (Velcade®)	*MM* 1.3 mg/m^2/dose for 9 multi-dose treatment cycles with retreatment if indicated.	1.3 mg/m^2/dose
Kyprolis® (carfilzomib)	*MM* • Varies	Varies
Ninlaro® (ixazomib)	*MM* 4 mg PO once weekly on days 1, 8, 15 of a 28-day treatment cycle	4 mg/day
First- and second-line therapies: • liposomal doxorubicin (Doxil, Lipodox 50) • paclitaxel	*KS* • Liposomal doxorubicin: 20 mg/m^2 IV every 2-3 weeks with a cumulative lifetime dose of 400-450 mg/m^2 due to cardiotoxicity • Paclitaxel: 135 mg/m^2 IV every 3 weeks **or** 100 mg/m^2 every 2 weeks	Varies
Drugs central to first-line therapy regimens: • bortezomib (Velcade®) • Revlimid® (lenalidomide) • melphalan (Alkeran®)	*Systemic Light Chain Amyloidosis* • Varies	Varies
Methotrexate (high-dose)	*Primary CNS Lymphoma* • 8 g/m^2 combined with rituximab or rituximab + temozolomide • 3.5 g/m^2 combined with vincristine + procarbazine + rituximab or temozolomide + rituximab	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): pregnancy, hypersensitivity
- Boxed warning(s): embryo-fetal toxicity; venous and arterial thromboembolism

Appendix D: General Information

- The NCCN recommends Pomalyst as a preferred 4th line therapy for AIDS-related KS, following HAART, liposomal doxorubicin, and paclitaxel. In Pomalyst's pivotal KS trial, 61% (11/18) of HIV-positive patients received prior chemotherapy.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MM	4 mg PO QD on days 1-21 of repeated 28-day cycles	4 mg/day
KS	5 mg PO QD on days 1-21 of repeated 28-day cycles* Continue HAART as HIV treatment in patients with AIDS-related KS	5 mg/day

**NCCN KS guidelines (version 1.2022): The NCCN recommends either 4 or 5 mg/day. Although the clinical trial used a dose of 5 mg/day, the NCCN Panel believes that 4 mg is a sufficient dose.*

VI. Product Availability

Capsules: 1 mg, 2 mg, 3 mg, 4 mg

VII. References

1. Pomalyst Prescribing Information. Summit, NJ: Celgene Corporation; October 2021. Available at http://www.celgene.com/content/uploads/pomalyst-pi.pdf. Accessed February 3, 2022.
2. Pomalidomide. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed February 3, 2022.
3. Central Nervous System Cancers (Version 2.2021). In: National Comprehensive Cancer Network Guidelines. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf. Accessed February 3, 2022.
4. Kaposi Sarcoma (Version 1.2022). In: National Comprehensive Cancer Network Guidelines. Available at https://www.nccn.org/professionals/physician_gls/pdf/kaposi.pdf. Accessed February 3, 2022.
5. Multiple Myeloma (Version 4.2022). In: National Comprehensive Cancer Network Guidelines. Available at: https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf. Accessed February 3, 2022.
6. Systemic Light Chain Amyloidosis (Version 1.2022). In: National Comprehensive Cancer Network Guidelines. Available at https://www.nccn.org/professionals/physician_gls/pdf/amyloidosis.pdf. Accessed February 3, 2022.
7. Lebbe C, Garbe C, Stratigos AJ, et al. Diagnosis and treatment of Kaposi's sarcoma: European consensus-based interdisciplinary guideline (EDF/EADO/EORTC). European Journal of Cancer. 2019; 114: 117-127.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2018 annual review: policies combined for Commercial and Medicaid; HIM line of business added; added age and COC; summarized NCCN and FDA approved uses for improved clarity; added specialist involvement in care; off-label Kaposi sarcoma and amyloidosis added; references updated.	02.13.18	05.18
2Q 2019 annual review: no significant changes; reference reviewed and updated.	01.30.19	05.19
2Q 2020 annual review: added NCCN compendium-supported indication of primary CNS lymphoma; references reviewed and updated.	02.14.20	05.20
RT2: Criteria revised for newly FDA approved indication of KS: allowed use in non-AIDS-related disease; added immunologist as a prescriber option per specialist feedback; for AIDS-related disease: added requirement that Pomalyst must be prescribed in combination with HAART and modified requirement from failure of 2 agents to specify first line doxorubicin and paclitaxel per NCCN and European consensus guidelines; modified max daily dose from 4 mg/day to 5 mg/day per FDA labeling.	06.30.20	08.20
2Q 2021 annual review: added hematology specialist option to MM and amyloidosis indications; for systemic light chain amyloidosis, added requirement for combination with dexamethasone per NCCN; references for HIM line of business off-label use revised from HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	02.19.21	05.21
Added requirement for no concurrent use with Revlimid or Thalomid since all are thalidomide analogs.	06.29.21	08.21
2Q 2022 annual review: modified commercial approval duration from length of benefit to "12 months or duration of request, whichever is less"; added oral oncology generic (if available) redirection language; per NCCN for KS applied requirement for failure of liposomal doxorubicin and paclitaxel to non-AIDS-related KS, for primary CNS lymphoma added additional use for induction therapy if unable to use high-dose methotrexate; for Kaposi sarcoma added dermatologist and infectious disease specialist to allowable specialist prescribers; references reviewed and updated.	02.03.22	05.22
Template changes applied to other diagnoses/indications.	09.30.22	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and

accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.