

Clinical Policy: Ixazomib (Ninlaro)

Reference Number: CP.PHAR.302

Effective Date: 02.01.17

Last Review Date: 08.22

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Ixazomib (Ninlaro[®]) is a proteasome inhibitor.

FDA Approved Indication(s)

Ninlaro is indicated in combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma (MM) who have received at least one prior therapy.

Limitations of Use: Ninlaro is not recommended for use in the maintenance setting or in newly diagnosed MM in combination with lenalidomide and dexamethasone outside of controlled clinical trials.

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 Ninlaro 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 \geq 18 years;
4. Member has received at least one prior therapy (*see Appendix B*);
5. Prescribed in one of the following ways (a or b):
 - a. In combination with dexamethasone with or without either Revlimid[®] or cyclophosphamide;*
 - b. All of the following (i, ii, and iii):
 - i. In combination with dexamethasone and Pomalyst[®];*
 - ii. Member has received at least two prior therapies including an immunomodulatory agent and a proteasome inhibitor;
 - iii. Member has demonstrated disease progression on or within 60 days of completion of the last therapy;
6. Request meets one of the following (a or b):*
 - a. Dose does not exceed 4 mg (1 tablet) per week for 3 weeks of a 28-day (4-week) treatment cycle;

**Prior authorization may be required for Revlimid, Pomalyst, or cyclophosphamide.*

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

- 1. Diagnosis of relapsed or refractory systemic light chain amyloidosis;
- 2. Prescribed by or in consultation with an oncologist or hematologist;
- 3. Age \geq 18 years;
- 4. Prescribed in one of the following ways (a, b, or c):
 - a. As a single agent;
 - b. In combination with dexamethasone;
 - c. In combination with dexamethasone and Revlimid;*

**Prior authorization may be required for Revlimid*

- 5. 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

C. Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma (off-label) (must meet all):

- 1. Diagnosis of Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma;
- 2. Prescribed by or in consultation with an oncologist or hematologist;
- 3. Age \geq 18 years;
- 4. Prescribed in combination with Rituxan[®]* and dexamethasone;
 - *Prior authorization may be required for Rituxan.*
- 5. 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

D. Other diagnoses/indications

- 1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): 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 (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Ninlaro for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):*
 - a. New dose does not exceed 4 mg (1 tablet) per week for 3 weeks of a 28-day (4-week) treatment cycle;
 - b. 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. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): 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

FDA: Food and Drug Administration

MM: multiple myeloma

NCCN: National Comprehensive Cancer Network

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
bortezomib/Revlimid [®] (lenalidomide) /dexamethasone	Varies	Varies
bortezomib/cyclophosphamide/dexamethasone	Varies	Varies
bortezomib/doxorubicin (or liposomal doxorubicin)/dexamethasone	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Kyprolis [®] (carfilzomib)/Revlimid [®] (lenalidomide) /dexamethasone	Varies	Varies
Kyprolis [®] (carfilzomib)/cyclophosphamide/ dexamethasone	Varies	Varies
bortezomib/dexamethasone	Varies	Varies
bortezomib/Thalomid [®] (thalidomide)/dexamethasone	Varies	Varies
cyclophosphamide/Revlimid [®] (lenalidomide)/dexamethasone	Varies	Varies
Revlimid [®] (lenalidomide)/dexamethasone	Varies	Varies
VTD-PACE (dexamethasone/Thalomid [®] (thalidomide)/cisplatin/doxorubicin/ cyclophosphamide/etoposide/bortezomib)	Varies	Varies
Revlimid [®] (lenalidomide)/low-dose dexamethasone	Varies	Varies
Darzalex [®] (daratumumab) or Darzalex Faspro [™] (daratumumab/hyaluronidase-fihj)/bortezomib/melphan/ prednisone	Varies	Varies
Darzalex [®] (daratumumab) or Darzalex Faspro [™] (daratumumab/hyaluronidase-fihj)/Revlimid [®] (lenalidomide)/ dexamethasone	Varies	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

None reported

Appendix D: General Information

- NCCN includes a category 2B recommendation for use of Ninlaro as maintenance therapy. The prescribing information for Ninlaro states that in two prospective randomized clinical trials in MM in the maintenance setting, treatment with Ninlaro resulted in increased deaths. Treatment of patients with Ninlaro for MM in the maintenance setting is not recommended outside of controlled trials.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MM	4 mg PO on Days 1, 8, and 15 of a 28-day cycle. See Ninlaro Prescribing Information for Revlimid and dexamethasone dosing.	4 mg/week for 3 weeks of a 28-day (4-week) treatment cycle

VI. Product Availability

Capsules: 2.3 mg, 3 mg, 4 mg

VII. References

1. Ninlaro Prescribing Information. Cambridge, MA: Millennium Pharmaceuticals, Inc.; April 2022. Available at <https://www.ninlaro.com/prescribing-information.pdf>. Accessed May 12, 2022.
2. National Comprehensive Cancer Network Drug and Biologics Compendium. Available at www.nccn.org. Accessed April 27, 2022.
3. National Comprehensive Cancer Network. Multiple Myeloma Version 5.2022. Available at https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf. Accessed April 27, 2022.
4. National Comprehensive Cancer Network. Systemic Light Chain Amyloidosis Version 1.2022. Available at https://www.nccn.org/professionals/physician_gls/pdf/amyloidosis.pdf. Accessed April 27, 2022.
5. National Comprehensive Cancer Network. Waldenstrom Macroglobulinemia / Lymphoplasmacytic Lymphoma Version 2.2022. Available at https://www.nccn.org/professionals/physician_gls/pdf/waldenstroms.pdf. Accessed April 27, 2022.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2018 annual review: policies combined for Commercial, HIM (new), and Medicaid lines of business; MM off-label uses added as subsequent therapy in combination with dexamethasone and Pomalyst and as primary therapy in combination with dexamethasone and Revlimid; NCCN and FDA-approved uses summarized for improved clarity (prior chemotherapy requirement removed given new off-label uses); references reviewed and updated.	05.08.18	08.18
3Q 2019 annual review: NCCN recommended off-label use added for systemic light chain amyloidosis; references reviewed and updated.	05.14.19	08.19
3Q 2020 annual review: NCCN recommended uses for MM and Waldenstrom added; references reviewed and updated.	05.12.20	08.20
3Q 2021 annual review: no significant changes; updated reference for HIM off-label use to HIM.PA.154 (replaces HIM.PHAR.21); references reviewed and updated.	04.02.21	08.21
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less	01.20.22	05.22
3Q 2022 annual review: for MM removed use as a single agent for subsequent therapy in transplant candidates as this has been downgraded to a NCCN category 2B recommendation; clarified combination use with dexamethasone and Pomalyst requires two prior therapies per NCCN; RT4: added limitations of use for maintenance therapy and newly diagnosed MM per updated prescribing information, for MM added requirement that member has received at least one prior therapy, removed maintenance use as a single agent after prior autologous stem cell transplant; for systemic light chain	05.12.22	08.22

Reviews, Revisions, and Approvals	Date	P&T Approval Date
amyloidosis added requirements for use as a single agent or in combination per NCCN; references reviewed and updated.		

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.

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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.

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