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| JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTHCARE | Johns Hopkins HealthCare LLC<br>**Pharmacy Public**<br>**Medical Management Drug Policies** | *Policy Number* | MMDP049 |
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| | | *Page* | 1 of 2 |

This document applies to the following Participating Organizations:

US Family Health Plan

**Keywords**: kyprolis

| Table of Contents | | Page Number |
|---|---|---|
| **I.** | **POLICY** | **1** |
| **II.** | **POLICY CRITERIA** | **1** |
| **III.** | **AUTHORIZATION PERIOD/LIMITATIONS** | **2** |
| **IV.** | **EXCLUSIONS** | **2** |
| **V.** | **RECOMMENDED DOSAGE** | **2** |
| **VI.** | **CODES** | **2** |
| **VII.** | **REFERENCES** | **2** |
| **VIII.** | **APPROVALS** | **2** |

## I. POLICY

A. Kyprolis (carfilzomib) will require prior authorization for medical benefit coverage to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.

## II. POLICY CRITERIA

A. Kyprolis may be approved for patients who meet the following:
   1. Multiple Myeloma
      a. Documentation has been submitted showing the patient has symptomatic multiple myeloma
      b. Documentation has been submitted showing one of the following:
         I. Kyprolis will be used as primary therapy in one of the following regimens:
            i. Combination therapy with lenalidomide and dexamethasone
            ii. Combination therapy with cyclophosphamide and dexamethasone
         II. Kyprolis will be used for treatment of relapsed or refractory disease in one of the following regimens after patients have had inadequate response to one or more lines of therapy:
            i. Monotherapy
            ii. Combination therapy with dexamethasone
            iii. Combination therapy with lenalidomide and dexamethasone
            iv. Combination therapy with cyclophosphamide and dexamethasone
            v. Combination therapy with cyclophosphamide, thalidomide, and dexamethasone
            vi. Combination therapy with daratumumab and dexamethasone
            vii. Combination therapy with panobinostat (Farydak) in patients that have experienced inadequate response with at least two prior regimens, including bortezomib (Velcade) and an immunomodulatory agent
            viii. Combination therapy with pomalidomide (Pomalyst) and dexamethasone in patients that have experienced inadequate response with at least two prior therapies, including an immunomodulatory agent and a proteasome inhibitor
            ix. Combination therapy with isatuximab-irfc (Sarclisa) and dexamethasone
   2. Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma

a. Documentation has been submitted supporting the patient's diagnosis, and showing Kyprolis will be used as a component of the CaRD (carfilzomib, rituximab, and dexamethasone) regimen.

## III. AUTHORIZATION PERIOD/LIMITATIONS

A. Initial approval will be limited to 12months of therapy
B. Continuation of therapy may be approved in 12-month intervals with documentation showing the patient is continuing to tolerate the regimen and there has not been disease progression while on treatment.

## IV. EXCLUSIONS

A. Kyprolis will not be covered for the following:
   1. Any indications or uses that are not FDA-approved or guideline-supported

## V. RECOMMENDED DOSAGE

A. Please refer to the FDA-approved prescribing information, and clinical guidelines for indication-specific dosing details.
B. For all indications, dosing does not exceed the following:
   a. If using twice weekly: 56 mg/m2 (not to exceed 124 mg) per dose, not to exceed 6 doses per 28 days
   b. If using once weekly: 70 mg/m2 (not to exceed 154 mg) per dose, not to exceed 3 doses per 28 days

## VI. CODES



**Note: The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/ HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member's specific benefit plan determines coverage.**

| Medication | HCPCS/CPT Code |
|---|---|
| Injection, carfilzomib, 1 mg | J9047 |

## VII. REFERENCES

1. Kyprolis [prescribing information ]. Thousand Oaks, CA: Onyx Pharmaceuticals, Inc.; November 2021.
2. The NCCN Drugs & Biologics Compendium 2022 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 2,2022.

## VIII. APPROVALS

Signature on file at JHHC

| DATE OF REVISION | SUMMARY OF CHANGE |
|---|---|
| 04/20/2022 | Policy Creation |

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