Clinical Policy: Panobinostat (Farydak)

Reference Number: ERX.SPA.09
Effective Date: 04.01.17
Last Review Date: 08.21
Line of Business: Commercial, Medicaid

Revision Log

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

Description
Panobinostat (Farydak®) is a histone deacetylase inhibitor.

FDA Approved Indication(s)
Farydak is indicated in combination with bortezomib and dexamethasone, for the treatment of patients with multiple myeloma (MM) who have received at least 2 prior regimens, including bortezomib and an immunomodulatory agent.

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.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Farydak 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 a hematologist or oncologist;
3. Age ≥ 18 years;
4. Failure of at least 2 prior regimens for MM including bortezomib and an immunomodulatory agent (e.g., dexamethasone), unless contraindicated or clinically significant adverse effects are experienced;
   **Prior authorization may be required for the 2 prior regimens*
5. Farydak is used in combination with one of the following (a, b, or c):
   a. Bortezomib and dexamethasone;
   b. Kyprolis®;
   c. Revlimid® and dexamethasone;
   **Prior authorization may be required for these agents*
6. Request meets one of the following (a or b):*
   a. Dose does not exceed six 20 mg doses per 21-day cycle for 16 cycles total;
   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:
Commercial – Length of Benefit
Medicaid – 6 months

B. Other diagnoses/indications

1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Multiple Myeloma (must meet all)**:**

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions, or documentation supports that member is currently receiving Farydak for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If used in combination with bortezomib and dexamethasone, member has not received more than 16 cycles (48 weeks) of therapy;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed six 20 mg doses per 21-day cycle for 16 cycles total;
   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:
Commercial – Length of Benefit
Medicaid – 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 policy – ERX.PA.01 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
REMS: risk evaluation and mitigation strategy

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 and may require prior authorization.

Drug Name*	Dosing Regimen	Dose Limit/ Maximum Dose
Darzalex® (daratumumab)	16 mg/kg IV administered: *As monotherapy or in combination with lenalidomide/ dexamethasone*: weekly for weeks 1 to 8, then every 2 weeks for weeks 9 to 24, then every 4 weeks for week 25 onward until disease progression *In combination with bortezomib/dexamethasone*: weekly for weeks 1 to 9, then every 3 weeks for weeks 10 to 24, then every 4 weeks for week 25 onward until disease progression	Varies
Doxil® (liposomal doxorubicin)	30 mg/m^2 IV over 1 hour on day 4 repeated every 3 weeks; used in combination with bortezomib	Varies
Empliciti™ (elotuzumab)	10 mg/kg IV every week for the first two cycles, then every 2 weeks thereafter until disease progression; used in combination with lenalidomide and dexamethasone	Varies
Kyprolis® (carfilzomib)	20 mg/m^2 IV on two consecutive days each week for 3 weeks (Days 1, 2, 8, 9, 15 and 16) followed by a 12-day rest period	Varies

Drug Name*	Dosing Regimen	Dose Limit/ Maximum Dose
	(Days 17 to 28). For cycle 13 and beyond omit doses on days 8 and 9. Dexamethasone premedication is required for each Kyprolis dose in cycle 1. Each 28-day period is considered one treatment cycle. If tolerated in cycle 1, the dose should be escalated to 27 mg/m^2 and in the subsequent cycles	
Ninlaro® (ixazomib)	4 mg PO on Days 1, 8, and 15 of a 28-day cycle; used in combination with lenalidomide and dexamethasone	4 mg/day
Pomalyst® (pomalidomide)	4 mg PO QD on days 1-21 of repeated 28-day cycles in combination with dexamethasone until disease progression	4 mg/day
Revlimid® (lenalidomide)	25 mg PO QD on days 1-21 of repeated 28 day cycles in combination with dexamethasone	25 mg/day
bortezomib (Velcade®)	1.3 mg/m^2 IV bolus or SC twice weekly, with at least 72 hours between doses (on days 1, 4, 8, 11, 22, 25, 29, and 32), for cycles 1 to 4; then once weekly for 6 weeks (on days 1, 8, 22, and 29) for cycles 5 through 9	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.
**Examples.*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): Because of severe diarrhea and cardiac toxicities, Farydak has a risk evaluation and mitigation strategy (REMS) program that consists of a Medication Guide and a Dear Healthcare Professional Letter. Patient and physician enrollment in the manufacturer's REMS program is required.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MM	20 mg PO every other week for 3 doses per week (on Days 1, 3, 5, 8, 10, and 12) of Weeks 1 and 2 for each 21-day cycle for 8 cycles. Consider continuing treatment for an additional 8 cycles for patients with clinical benefit who do not experience unresolved severe or medically significant toxicity (total treatment duration: up to 16 cycles [48 weeks]). _____ The recommended dose of bortezomib is 1.3 mg/m^2 given as an injection. The recommended dose of dexamethasone is 20 mg PO per scheduled day, on a full stomach. See Farydak Prescribing Information for cycle schedules.	20 mg/dose

VI. Product Availability

Capsules: 10 mg, 15 mg, 20 mg

VII. References

1. Farydak Prescribing Information. East Hanover, MJ: Novartis Pharmaceuticals; September 2019. Available at: https://www.pharma.us.novartis.com/files/farydak.pdf. Accessed April 2, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at http://www.nccn.org/professionals/drug_compendium. Accessed April 2, 2021.
3. National Comprehensive Cancer Network. Multiple Myeloma Version 5.2021. Available at: http://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf. Accessed April 2, 2021.
4. Clinical Pharmacology [database online]. Tampa, FL. Available at: http://clinicalpharmacology-ip.com. Accessed April 2, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01.17	02.17
1Q18 annual review: Added age limit per PI. Added NCCN Compendium supported use in combination with dexamethasone and Revlimid. Added continuation of care language in Section II.	11.10.17	02.18
3Q 2018 annual review: no significant changes; specialist requirement added; references reviewed and updated.	04.26.18	08.18
3Q 2019 annual review: no significant changes; added hematologist prescriber option; limited number of cycles to 16 per PI; added Medicaid line of business with 6/12 month approval durations; references reviewed and updated.	05.14.19	08.19
3Q 2020 annual review: no significant changes; references reviewed and updated.	05.12.20	08.20
3Q 2021 annual review: no significant changes; references reviewed and updated.	04.02.21	08.21

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.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.