Clinical Policy: Thalidomide (Thalomid)
Reference Number: ERX.SPA.44
Effective Date: 07.01.16
Last Review Date: 05.19

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

Description
Thalidomide (Thalomid®) is an immunomodulatory agent.

FDA Approved Indication(s)
Thalomid is indicated:
• For the treatment of patients with newly diagnosed multiple myeloma (MM) in combination with dexamethasone
• For the acute treatment of the cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL)
• As maintenance therapy for prevention and suppression of the cutaneous manifestations of ENL recurrence

Limitation(s) of use: Thalomid is not indicated as monotherapy for such ENL treatment in the presence of moderate to severe neuritis.

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 Thalomid 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;
      3. Age ≥ 12 years;
      4. Prescribed in combination with dexamethasone;
      5. Request meets one of the following (a or b):
         a. Dose does not exceed 200 mg per day;
         b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

   Approval duration: Length of Benefit

   B. Erythema Nodosum Leprosum (must meet all):
      1. Diagnosis of ENL;
      2. Prescribed by or in consultation with an infectious disease specialist, immunologist, or dermatologist;
      3. Age ≥ 12 years;
      4. Dose does not exceed 400 mg per day.

   Approval duration: Length of Benefit

   C. Myeloproliferative Neoplasms (off-label) (must meet all):
      1. Diagnosis of myeloproliferative neoplasms (myelofibrosis) with associated anemia;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 12 years;
4. Member meets one of the following (a or b):
   a. Serum EPO ≥ 500 mU/mL;
   b. Serum EPO < 500 mU/mL, and no response or loss of response to erythropoietic stimulating agents;
5. Request meets one of the following (a or b):
   a. Dose does not exceed 400 mg per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

Approval duration: Length of Benefit

D. Castleman's Disease (off-label) (must meet all):
1. Diagnosis of multicentric Castleman’s disease;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 12 years;
4. Prescribed as subsequent therapy with or without rituximab for disease that has progressed following treatment of relapsed/refractory or progressive disease;
5. Request meets one of the following (a or b):
   a. Dose does not exceed 400 mg per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

Approval duration: Length of Benefit

E. Kaposi Sarcoma (off-label) (must meet all):
1. Diagnosis of AIDS-related Kaposi Sarcoma;
2. Prescribed by or in consultation with an oncologist or immunologist;
3. Age ≥ 12 years;
4. Prescribed in combination with antiretroviral therapy;
5. Disease has progressed or not responded to doxorubicin and paclitaxel;
6. Request meets one of the following (a or b):
   a. Dose does not exceed 400 mg per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

Approval duration: Length of Benefit

F. 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. All Indications in Section I (must meet all):
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions or documentation supports that member is currently receiving Thalomid 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 400 mg per day;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

Approval duration: Length of Benefit

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.
CLINICAL POLICY
Thalidomide

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
doctoration 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
ENL: erythema nodosum leprosum
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 and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/ Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>doxorubicin</td>
<td>Kaposi sarcoma: 20 mg/m² IV every 3 weeks</td>
<td>20 mg/m²/dose</td>
</tr>
<tr>
<td>paclitaxel</td>
<td>Kaposi sarcoma: 100 mg/m² IV every 2 weeks</td>
<td>100 mg/m²/dose</td>
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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 and venous thromboembolism

Appendix D: General Information
- Thalomid is only available under a restricted distribution program called the Thalomid REMS program due to a black box warning for embryo-fetal toxicity. Patient and physician enrollment in the manufacturer's REMS program is required.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
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<tbody>
<tr>
<td>MM</td>
<td>200 mg PO QD</td>
<td>200 mg/day</td>
</tr>
<tr>
<td>ENL</td>
<td>100 to 300 mg PO QD</td>
<td>400 mg/day</td>
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VI. Product Availability
Capsules: 50 mg, 100 mg, 150 mg, 200 mg

VII. References
Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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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.

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