SmartHealth Ascension

Bortezomib

(Velcade®) J9041 (0.1mg)

Covered with prior authorization

Bortezomib (Velcade®) may be authorized when the following criteria are met:

Individual has a diagnosis of one of the following:

- Multiple myeloma
- One of the following non-Hodgkin lymphomas
  - Mantle cell lymphoma; **OR**
  - Peripheral T-cell lymphomas (that is, peripheral T-cell lymphoma [PTCL], anaplastic large cell lymphoma [ALCL], or angioimmunoblastic T-cell lymphoma [AITL]) as therapy for refractory or relapsed disease; **OR**
  - Waldenström's macroglobulinemia/ lymphoplasmacytic lymphoma
- Systemic light chain amyloidosis
- Other rare plasma cell dyscrasias requiring treatment, including but not limited to, POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes) syndrome.

Exclusion criteria:
Requests for Bortezomib (Velcade®) may not be approved for the following:

- Chronic lymphocytic lymphoma (CLL)
- Chronic myeloid leukemia (CML)
- Diffuse large B-cell lymphoma (DLBCL)
- Follicular lymphoma (FL)
- Gastric and non-gastric mucosa-associated lymphoid tissue (MALT) lymphoma
- Hodgkin lymphoma (HL)
- Mycosis fungoides/Sézary syndrome
- Myelodysplastic syndrome
- Neuroendocrine tumors (for example, carcinoid or islet cell tumors)
- Sarcoma (for example, osteosarcoma)
- Solid tumors (for example, biliary tract, colorectal, head and neck, metastatic melanoma (lung), non-small cell lung cancer [NSCLC], or pancreatic carcinoma)
- Solitary plasmacytoma
- Product use for non-FDA approved indications or indications not supported by industry-accepted guidelines
- Doses, durations, or dosing intervals that exceed FDA maximum limits for any FDA-approved indication or are not supported by industry-accepted practice guidelines or peer-reviewed literature for the relevant off-label use

Initial authorization is up to 12 months.

Annual reauthorizations will require medical chart documentation that the patient has been seen within the past 12 months and has not had disease progression during treatment.

Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

U.S. Food and Drug Administration:
This section is to be used for informational purposes. FDA approval alone is not a basis for coverage.

VELCADE® is a proteasome inhibitor indicated for:

- Treatment of adult patients with multiple myeloma
- Treatment of adult patients with mantle cell lymphoma

References:

1. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website.
2. Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2022; Updated periodically.
3. NCCN Clinical Practice Guidelines in Oncology™. © 2022 National Comprehensive Cancer Network, Inc. For additional information visit the NCCN website: http://www.nccn.org/index.asp
4. Velcade® [Prescribing Information]. Lexington, MA: Takeda Pharmaceuticals U.S.A.; 2021

Date	Summary of Changes
August 2022	Criteria for use summary developed by the Ascension Medical Specialty Prior Authorization Team.
September 2022	Criteria for use summary approved by the Ascension Ambulatory Care Expert Review Panel.
October 2022	Criteria for use summary approved by the Ascension Therapeutic Affinity Group.

If you have questions, call 833-980-2352 to speak to a member of the Ascension Rx prior authorization team, or email your questions to smarthealthspecialty@ascension.org.