PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Injectable) – Darzalex Intravenous Prior Authorization Policy
- Darzalex™ (daratumumab intravenous infusion – Janssen Biotech)

REVIEW DATE: 04/24/2024

OVERVIEW

Darzalex, a CD38-directed cytolytic antibody, is indicated for treatment of **multiple myeloma** in the following situations:[1]

- in newly diagnosed patients, in combination with lenalidomide and dexamethasone, for the treatment of patients who are ineligible for autologous stem cell transplant and in relapsed/refractory disease, in combination with lenalidomide and dexamethasone in patients who have received at least one prior therapy.
- in newly diagnosed patients, in combination with bortezomib, melphalan, and prednisone in those ineligible for autologous stem cell transplant.
- in newly diagnosed patients, in combination with bortezomib, Thalomid® (thalidomide capsules), and dexamethasone, for treatment of patients who are eligible for autologous stem cell transplant.
- in patients who have received at least one prior therapy, in combination with bortezomib and dexamethasone.
- in patients who have received at least two prior therapies (including lenalidomide and a proteasome inhibitor), in combination with Pomalyst® (pomalidomide capsules) and dexamethasone.
- in patients who have received at least three prior lines of therapy (including a proteasome inhibitor and an immunomodulatory agent or who are double-refractory to a proteasome inhibitor and an immunomodulatory agent), as monotherapy.
- in relapsed/refractory disease, in combination with Kyprolis® (carfilzomib intravenous infusion) and dexamethasone in patients who have received one to three prior lines of therapy.

Guidelines

Darzalex Intravenous is discussed in guidelines from the National Comprehensive Cancer Network (NCCN).

- **Multiple Myeloma:** NCCN guidelines (version 3.2024 – March 8, 2024) recommend Darzalex in treatment regimens for primary therapy.[2-3] Darzalex/lenalidomide/bortezomib/dexamethasone, Darzalex/bortezomib/Thalomid/dexamethasone, Darzalex/Kyprolis/lenalidomide/dexamethasone, and Darzalex/cyclophosphamide/bortezomib/dexamethasone are among the recommended regimens for primary therapy for transplant candidates. For patients who are non-transplant candidates, Darzalex with: lenalidomide/dexamethasone (preferred; category 1), and bortezomib/melphalan/prednisone, (category 1) and cyclophosphamide/bortezomib/dexamethasone are among the regimens for primary treatment. All other recommendations are category 2A. For previously treated multiple myeloma (one to three prior therapies), Darzalex/dexamethasone plus bortezomib (category 1), lenalidomide (category 1), Pomalyst, or Kyprolis (category 1) are among the Preferred regimens, whereas other Darzalex-containing regimens are listed as other or useful in certain circumstances. Darzalex ± lenalidomide has been added under "Useful in Certain Circumstances" for maintenance therapy in transplant candidates.
- **Pediatric Acute Lymphoblastic Leukemia:** NCCN guidelines (version 5.2024 – April 3, 2024) recommend Darzlex-containing regimen as one of the "Other Recommended Regimens" for relapsed/refractory disease (category 2A).[6]

- **Systemic Light Chain Amyloidosis:** The NCCN guidelines (version 2.2024 – December 12, 2023) list Darzalex Intravenous as a therapy for previously treated disease, or for newly diagnosed disease (both category 2A).[4] In both settings Darzalex is recommended as a single agent. Of note, Darzalex Faspro is indicated and is specifically recommended as a preferred first-line therapy for systemic light chain amyloidosis, given in combination with cyclophosphamide and dexamethasone.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Darzalex. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Darzalex as well as the monitoring required for adverse events and long-term efficacy, approval requires Darzalex to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Darzalex Intravenous is recommended in those who meet one of the following criteria:

FDA-Approved Indication

1. **Multiple Myeloma**. Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient meets ONE of the following (i or ii):
     - **i.** Darzalex is used in combination with at least two other therapies; OR
       Note: Examples of therapies that may be used in combination with Darzalex include dexamethasone or prednisone, lenalidomide, Pomalyst (pomalidomide capsules), Thalomid (thalidomide capsules), melphalan, bortezomib, or Kyprolis (carfilzomib intravenous infusion).
     - **ii.** Patient meets ONE of the following (a or b):
       - **a)** Patient has tried at least three different regimens for multiple myeloma; OR
         Note: Examples of agents used in other regimens include bortezomib, Kyprolis, lenalidomide, cyclophosphamide, Ninlaro (ixazomib capsules).
       - **b)** Darzalex is used as maintenance therapy in a transplant candidate; AND
   - **C)** The medication is prescribed by or in consultation with an oncologist or a hematologist.

Other Uses with Supportive Evidence

2. **Pediatric Acute Lymphoblastic Leukemia.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   - **A)** Patient is ≤ 18 years of age; AND
   - **B)** Patient has relapsed or refractory disease; AND
   - **C)** The medication is prescribed by or in consultation with an oncologist.

Systemic Light Chain Amyloidosis. Approve for 1 year if the patient meets ALL of the following (A, B, and C):

A) Patient is ≥ 18 years of age; AND

B) Patient meets ONE of the following (i or ii):

i. The medication will be used as a single agent for newly diagnosed disease; OR

ii. The medication will be used as a single agent for relapsed/refractory disease; AND

C) The medication is prescribed by or in consultation with an oncologist or a hematologist.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Darzalex Intravenous is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Darzalex [prescribing information]. Horsham, PA: Janssen Biotech; January 2023.
2. The NCCN Drugs and Biologics Compendium. © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 15, 2024. Search term: daratumumab.
3. The NCCN Multiple Myeloma Clinical Practice Guidelines in Oncology (version 3.2024 – March 8, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 15, 2024.
4. The NCCN Systemic Light Chain Amyloidosis Clinical Practice Guidelines in Oncology (version 2.2024 – December 12, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 15, 2024.
5. Kaufman GP, Schrier SL, Lafayette RA, et al. Daratumumab yields rapid and deep hematologic responses in patients with heavily pretreated AL amyloidosis. *Blood*. 2017;130(7):900-902.
6. The NCCN Pediatric Acute Lymphoblastic Leukemia Clinical Practice Guidelines in Oncology (version 5.2024 – April 3, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 17, 2024.