Specialty Guideline Management

POMALYST (pomalidomide)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications
Treatment of multiple myeloma, in combination with dexamethasone, in patients who have received at least two prior therapies including lenalidomide and a proteasome inhibitor and have demonstrated disease progression on or within 60 days of completion of their last therapy

B. Compendial Uses
Systemic light chain amyloidosis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Multiple myeloma
Authorization of 12 months may be granted for the treatment of multiple myeloma when the member has previously received at least two prior therapies for multiple myeloma.

B. Systemic light chain amyloidosis
Authorization of 12 months may be granted for the treatment of systemic light chain amyloidosis.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Pomalyst [package insert]. Summit, NJ: Celgene Corporation; June 2016.
2. The NCCN Drugs & Biologics Compendium® © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed October 26, 2016.
3. The NCCN Clinical Practice Guidelines in Oncology® Multiple Myeloma (Version 1.2017) © 2016 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed October 20, 2016.
4. The NCCN Clinical Practice Guidelines in Oncology® Systemic Light Chain Amyloidosis (Version 1.2016) © 2016 National Comprehensive Cancer Network, Inc. Available at: www.nccn.org. Accessed September 28, 2016.