Reference number(s)
1705-A

SPECIALTY GUIDELINE MANAGEMENT

TREANDA (bendamustine)
BENDEKA (bendamustine)

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[1,2]
1. Chronic lymphocytic leukemia (CLL)
2. Indolent B-cell non-Hodgkin lymphoma (NHL) that has progressed during or within six months of treatment with rituximab or a rituximab-containing regimen

B. Compendial Uses[3,4]
1. Classical Hodgkin lymphoma (CHL)
2. Multiple myeloma (MM)
3. Non-Hodgkin lymphoma (NHL)
   i. Adult T-cell leukemia/lymphoma (ATLL)
   ii. Acquired immune deficiency syndrome (AIDS)-related B-cell lymphoma
   iii. CLL/small lymphocytic lymphoma (SLL)
   iv. Diffuse large B-cell lymphoma (DLBCL)
   v. Follicular lymphoma
   vi. Marginal zone lymphoma
      a. Nodal marginal zone lymphoma
      b. Gastric mucosa associated lymphoid tissue (MALT) lymphoma
      c. Nongastric MALT lymphoma
      d. Splenic marginal zone lymphoma
   vii. Mantle cell lymphoma (MCL)
   viii. Mycosis fungoides (MF)/Sezary syndrome (SS)
   ix. Peripheral T-cell lymphoma (PTCL)
   x. Primary cutaneous B-cell lymphoma
   xi. Primary cutaneous CD30+ T-cell lymphoproliferative disorder
   xii. Post-transplant lymphoproliferative disorders
4. Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma

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

II. CRITERIA FOR INITIAL APPROVAL

A. Non-Hodgkin lymphoma (NHL)[1-4]
Authorization of 12 months may be granted for treatment of NHL with any of the following subtypes:
1. Follicular lymphoma

2. Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) without chromosome 17p deletion or TP53 mutation
3. Diffuse large B-cell lymphoma (DLBCL)
4. Adult T-cell leukemia/lymphoma (ATLL)
5. AIDS-related B-cell lymphoma
6. Marginal zone lymphoma
    i. Nodal marginal zone lymphoma
    ii. Gastric MALT lymphoma
    iii. Nongastric MALT lymphoma
    iv. Splenic marginal zone lymphoma
7. Mantle cell lymphoma (MCL)
8. Mycosis fungoides (MF)/Sezary syndrome (SS)
9. Peripheral T-cell lymphoma (PTCL)
10. Primary cutaneous B-cell lymphoma
11. Cutaneous anaplastic large cell lymphoma (ALCL)
12. Post-transplant lymphoproliferative disorders

B. Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma[3]
Authorization of 12 months may be granted for treatment of Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma.

C. Multiple myeloma (MM)[3]
Authorization of 12 months may be granted for treatment of MM.

D. Classical Hodgkin lymphoma (CHL)[3]
Authorization of 12 months may be granted for treatment of CHL.

III. CONTINUATION OF THERAPY

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

IV. REFERENCES

1. Treanda [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc.; December 2017.
2. Bendeka [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc.; September 2017.
3. The NCCN Drugs & Biologics Compendium® © 2018 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed March 30, 2018.
4. Clinical Consult: CVS Caremark Clinical Programs Review. Focus on Hematology-Oncology Clinical Programs. June 2018