SPECIALTY GUIDELINE MANAGEMENT

VELCADE (bortezomib)
bortezomib

POLICY

I. INDICATIONS

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

A. FDA-Approved Indications
   1. Multiple myeloma
   2. Mantle cell lymphoma

B. Compendial Uses
   1. Systemic light chain amyloidosis
   2. Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma
   3. Multicentric Castleman's disease
   4. Adult T-cell leukemia/lymphoma
   5. Primary cutaneous anaplastic large cell lymphoma

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

II. CRITERIA FOR INITIAL APPROVAL

A. Multiple myeloma
   Authorization of 12 months may be granted for the treatment of multiple myeloma.

B. Mantle cell lymphoma
   Authorization of 12 months may be granted for the treatment of mantle cell lymphoma.

C. Multicentric Castleman's disease
   Authorization of 12 months may be granted for the treatment of multicentric Castleman's disease.

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

E. Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma
   Authorization of 12 months may be granted for the treatment of Waldenström’s macroglobulinemia/lymphoplasmacytic lymphoma.

F. Adult T-cell Leukemia/Lymphoma
   Authorization of 12 months may be granted for the treatment of adult T-cell leukemia/lymphoma.

G. Primary cutaneous anaplastic large cell lymphoma
   Authorization of 12 months may be granted for the treatment of primary cutaneous anaplastic large cell lymphoma (ALCL).

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III. CONTINUATION OF THERAPY

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

IV. REFERENCES