



Darzalex® (daratumumab) (Intravenous)

Document Number: IC-0266

Last Review Date: 06/02/2020

Date of Origin: 02/23/2016

Dates Reviewed: 02/2016, 12/2016, 02/2017, 05/2017, 06/2017, 11/2017, 02/2018, 05/2018, 06/2018, 09/2018, 12/2018, 03/2019, 06/2019, 08/2019, 10/2019, 12/2019, 03/2020, 06/2020

I. Length of Authorization^{1,6}

- Use for newly diagnosed multiple myeloma in combination with bortezomib, thalidomide, and dexamethasone may not be renewed.
- For use in all other multiple myeloma treatment settings and in systemic light chain amyloidosis, coverage will be provided for 6 months and may be renewed.

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

- Darzalex 100 mg single-dose vial for injection: 3 vials per dose
 - Weekly Weeks 1 to 6, then every three weeks Weeks 7-54, then every four weeks Week 55 onwards **OR**
 - Weekly Weeks 1 to 8, then every two weeks Weeks 9-24, then every four weeks Week 25 onwards **OR**
 - Weekly Weeks 1 to 9, then every three weeks Weeks 10-24, then every four weeks Week 25 onwards **OR**
 - Weekly Weeks 1 to 8, then every two weeks Weeks 9-16 for induction therapy, then every two weeks Weeks 1 to 8 for consolidation therapy
- Darzalex 400 mg single-dose vial for injection: 4 vials per dose
 - Weekly Weeks 1 to 6, then every three weeks Weeks 7-54, then every four weeks Week 55 onwards **OR**
 - Weekly Weeks 1 to 8, then every two weeks Weeks 9-24, then every four weeks Week 25 onwards **OR**
 - Weekly Weeks 1 to 9, then every three weeks Weeks 10-24, then every four weeks Week 25 onwards **OR**
 - Weekly Weeks 1 to 8, then every two weeks Weeks 9-16 for induction therapy, then every two weeks Weeks 1 to 8 for consolidation therapy

B. Max Units (per dose and over time) [HCPCS Unit]:

- Bortezomib/Melphalan/Prednisone Regimen

- 180 billable units per dose
(*Weekly Weeks 1 to 6, then every three weeks Weeks 7-54, then every four weeks Week 55 onwards*)
- Lenalidomide/Pomalidomide/Carfilzomib Regimen
 - 180 billable units per dose
(*Weekly Weeks 1 to 8, then every two weeks Weeks 9-24, then every four weeks Week 25 onwards*)
- Bortezomib Regimen
 - 180 billable units per dose
(*Weekly Weeks 1 to 9, then every three weeks Weeks 10-24, then every four weeks Week 25 onwards*)
- Monotherapy Regimen
 - 180 billable units per dose
(*Weekly Weeks 1 to 8, then every two weeks Weeks 9-24, then every four weeks Week 25 onwards*)
- Bortezomib/Thalidomide Regimen
 - 180 billable units per dose
(*Weekly Weeks 1 to 8, then every two weeks Weeks 9-16 for induction therapy, then every two weeks Weeks 1 to 8 for consolidation therapy*)

III. Initial Approval Criteria ¹

Coverage is provided in the following conditions:

- Patient is 18 years or older; **AND**

Universal Criteria

- Will not be used in combination with other anti-CD38 therapies (i.e., daratumumab, isatuximab, etc.); **AND**

Multiple Myeloma † Φ ^{1,2,3,4,5,6,7,8,9,10}

- Used in the treatment of newly diagnosed disease in patients who are ineligible for autologous stem cell transplant (ASCT) in combination with ONE of the following regimens:
 - Lenalidomide and dexamethasone; **OR**
 - Bortezomib, melphalan, and prednisone; **OR**
- Used in the treatment of newly diagnosed disease in patients who are eligible for autologous stem cell transplant (ASCT) in combination with bortezomib, thalidomide, and dexamethasone (VTd); **OR**
- Used for disease relapse after 6 months following primary induction therapy with the same regimen in combination with lenalidomide and dexamethasone for non-transplant candidates; **OR**
- Used as subsequent therapy in combination with dexamethasone and either lenalidomide, bortezomib, or carfilzomib; **OR**
- Used in combination with pomalidomide and dexamethasone after at least two prior therapies including an immunomodulatory agent (e.g., lenalidomide, pomalidomide, etc.) and a proteasome inhibitor (bortezomib, carfilzomib, etc.); **OR**

- Used as single agent therapy; **AND**
 - Patient received at least three previous lines of therapy including a proteasome inhibitor (e.g., bortezomib, carfilzomib, etc.) and an immunomodulatory agent (e.g., lenalidomide, pomalidomide, etc.); **OR**
 - Patient is double-refractory to a proteasome inhibitor and an immunomodulatory agent

Systemic Light Chain Amyloidosis †^{2,12}

- Used as single agent therapy; **AND**
- Used for the treatment of relapsed/refractory disease

† FDA Approved Indication(s); ‡ Compendia recommended indication(s); Ⓢ Orphan Drug

IV. Renewal Criteria ^{1,2,3}

Coverage can be renewed based upon the following criteria:

- Patient continues to meet universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Disease response with treatment as defined by stabilization of disease and decrease in size of tumor or tumor spread; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe infusion reactions including anaphylactic reactions, neutropenia, thrombocytopenia, etc.; **AND**
- Use for newly diagnosed disease in combination with bortezomib, thalidomide, and dexamethasone after 24 weeks of induction/consolidation therapy may not be renewed

V. Dosage/Administration ^{1,3,5,12}

Indication	Dose
Multiple Myeloma	<u>Newly diagnosed disease in patients ineligible for ASCT in combination with bortezomib, melphalan and prednisone</u> <ul style="list-style-type: none"> ▪ 16 mg/kg body weight given as an intravenous infusion in a 6 week cycle: <ul style="list-style-type: none"> – Weekly Weeks 1 to 6 (six doses; cycle 1) – Every three weeks Weeks 7 to 54 (16 doses; cycles 2 to 9) – Every four weeks Week 55 onwards until disease progression (cycle 10 and beyond)
	<u>Newly diagnosed disease in patients eligible for ASCT in combination with bortezomib, thalidomide and dexamethasone</u> <ul style="list-style-type: none"> ▪ 16 mg/kg body weight given as an intravenous infusion in a 4 week cycle: <ul style="list-style-type: none"> ▪ Induction – <ul style="list-style-type: none"> – Weekly Weeks 1 to 8 (eight doses; cycles 1 and 2) – Every two weeks Weeks 9 to 16 (four doses; cycles 3 and 4) <p><i>Stop for high dose chemotherapy and ASCT</i></p> ▪ Consolidation –

	<p>– Every two weeks Weeks 1 to 8 (four doses; cycles 5 and 6)</p> <p><u>Treatment as one of the following:</u></p> <ul style="list-style-type: none"> • Monotherapy for patients with relapsed/refractory multiple myeloma • Combination therapy with lenalidomide and low-dose dexamethasone for newly diagnosed patients ineligible for ASCT • Combination therapy with lenalidomide, pomalidomide, or carfilzomib and low-dose dexamethasone in patients with relapsed/refractory disease <p>▪ 16 mg/kg body weight given as an intravenous infusion in a 4 week cycle:</p> <ul style="list-style-type: none"> – Weekly Weeks 1 to 8 (eight doses; cycles 1 and 2) – Every two weeks 9 to 24 (eight doses; cycles 3 to 6) – Every four weeks Week 25 onwards until disease progression (cycle 7 and beyond) <p><u>Combination therapy with bortezomib and dexamethasone for relapsed/refractory disease</u></p> <p>▪ 16 mg/kg body weight given as an intravenous infusion in a 3 week cycle:</p> <ul style="list-style-type: none"> – Weekly Weeks 1 to 9 (nine doses; cycles 1 to 3) – Every three weeks Weeks 10 to 24 (five doses; cycles 4 to 8) – Every four weeks Week 25 onwards until disease progression (cycle 9 and beyond)
Systemic Light Chain Amyloidosis	<p>▪ 16 mg/kg body weight given as an intravenous infusion:</p> <ul style="list-style-type: none"> – Weekly Weeks 1 to 8 (eight doses) – Every two weeks Weeks 9 to 24 (eight doses) – Every four weeks Week 25 onwards until disease progression
<p><i>*To facilitate administration, the first prescribed 16 mg/kg dose at Week 1 may be split over two consecutive days i.e. 8 mg/kg on Day 1 and Day 2 respectively.</i></p> <p><i>Note: Initiate antiviral prophylaxis to prevent herpes zoster reactivation within 1 week after starting Darzalex and continue for 3 months following treatment.</i></p>	

VI. Billing Code/Availability Information

HCPCS code:

- J9145 - Injection, daratumumab, 10 mg; 1 billable unit = 10 mg

NDC(s):

- Darzalex 100 mg/5 mL single-dose vial: 57894-0502-xx
- Darzalex 400 mg/20 mL single-dose vial: 57894-0502-xx

VII. References

1. Darzalex [package insert]. Horsham, PA; Janssen Biotech, Inc; April 2020. Accessed April 2020.
2. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) for daratumumab. National Comprehensive Cancer Network, 2020. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed April 2020.

3. Chari A, Martinez-Lopez J, Mateos MV, et al. Daratumumab plus carfilzomib and dexamethasone in patients with relapsed or refractory multiple myeloma. *Blood*. 2019 Aug 1;134(5):421-431. doi: 10.1182/blood.2019000722. Epub 2019 May 21.
4. Facon T, Kumar S, Plesner T, et al. Daratumumab plus Lenalidomide and Dexamethasone for Untreated Myeloma. *N Engl J Med*. 2019 May 30;380(22):2104-2115. doi: 10.1056/NEJMoa1817249.
5. Mateos MV, Dimopoulos MA, Cavo M, et al. Daratumumab plus Bortezomib, Melphalan, and Prednisone for Untreated Myeloma. *N Engl J Med*. 2018 Feb 8;378(6):518-528. doi: 10.1056/NEJMoa1714678. Epub 2017 Dec 12.
6. Moreau P, Attal M, Hulin C, et al. Bortezomib, thalidomide, and dexamethasone with or without daratumumab before and after autologous stem-cell transplantation for newly diagnosed multiple myeloma (CASSIOPEIA): a randomised, open-label, phase 3 study. *Lancet*. 2019 Jul 6;394(10192):29-38. doi: 10.1016/S0140-6736(19)31240-1. Epub 2019 Jun 3.
7. Dimopoulos MA, Oriol A, Nahi H, et al. Daratumumab, Lenalidomide, and Dexamethasone for Multiple Myeloma. *N Engl J Med*. 2016 Oct 6;375(14):1319-1331.
8. Palumbo A, Chanan-Khan A, Weisel K, et al. Daratumumab, Bortezomib, and Dexamethasone for Multiple Myeloma. *N Engl J Med*. 2016 Aug 25;375(8):754-66. doi: 10.1056/NEJMoa1606038.
9. Chari A, Suvannasankha A, Fay JW, et al. Daratumumab plus pomalidomide and dexamethasone in relapsed and/or refractory multiple myeloma. *Blood*. 2017 Aug 24;130(8):974-981. doi: 10.1182/blood-2017-05-785246. Epub 2017 Jun 21.
10. Lonial S, Weiss BM, Usmani SZ, et al. Daratumumab monotherapy in patients with treatment-refractory multiple myeloma (SIRIUS): an open-label, randomised, phase 2 trial. *Lancet*. 2016 Apr 9;387(10027):1551-1560. doi: 10.1016/S0140-6736(15)01120-4. Epub 2016 Jan 7.
11. Lokhorst HM, Plesner T, Laubach JP, et al. Targeting CD38 with Daratumumab Monotherapy in Multiple Myeloma. *N Engl J Med*. 2015 Sep 24;373(13):1207-19. doi: 10.1056/NEJMoa1506348. Epub 2015 Aug 26.
12. Kaufman GP, Schrier SL, Lafayette RA, et al. Daratumumab yields rapid and deep hematologic responses in patients with heavily pretreated AL amyloidosis. *Blood*. 2017 Aug 17;130(7):900-902. doi: 10.1182/blood-2017-01-763599. Epub 2017 Jun 14.
13. CGS Administrators, LLC. Local Coverage Article: Billing and Coding: Daratumumab (DARZALEX)-J9145 (A57243). Centers for Medicare & Medicaid Services, Inc. Updated on 09/18/2019 with effective date 09/26/2019. Accessed April 2020.
14. Palmetto GBA, LLC. Local Coverage Article: Billing and Coding: Chemotherapy (A56141). Centers for Medicare & Medicaid Services, Inc. Updated on 03/24/2020 with effective date 04/30/2020. Accessed April 2020.

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
C90.00	Multiple myeloma not having achieved remission

DARZALEX® (daratumumab) Prior Auth Criteria

Proprietary Information. Restricted Access – Do not disseminate or copy without approval.

©2020, Magellan Rx Management

ICD-10	ICD-10 Description
C90.02	Multiple myeloma, in relapse
C90.10	Plasma cell leukemia not having achieved remission
C90.12	Plasma cell leukemia in relapse
C90.20	Extramedullary plasmacytoma not having achieved remission
C90.22	Extramedullary plasmacytoma in relapse
C90.30	Solitary plasmacytoma not having achieved remission
C90.32	Solitary plasmacytoma in relapse
E85.81	Light chain (AL) amyloidosis
E85.89	Other amyloidosis
E85.9	Amyloidosis, unspecified
Z85.79	Personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) may exist and compliance with these policies is required where applicable. They can be found at:

<http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx>. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA):

Jurisdiction(s): 15	NCD/LCD/LCA Document (s): A57243
https://www.cms.gov/medicare-coverage-database/search/article-date-search.aspx?DocID=A57243&bc=gAAAAAAAAAAAA	

Jurisdiction(s): J & M	NCD/LCD/LCA Document (s): A56141
https://www.cms.gov/medicare-coverage-database/search/article-date-search.aspx?DocID=A56141&bc=gAAAAAAAAAAAA	

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)

Medicare Part B Administrative Contractor (MAC) Jurisdictions

Jurisdiction	Applicable State/US Territory	Contractor
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC