Clinical Policy: Belinostat (Beleodaq)

Reference Number: PA.CP.PHAR.311
Effective Date: 01/2018
Last Review Date: 10/2024

Description
Belinostat (Beleodaq®) is a histone deacetylase inhibitor.

FDA Approved Indication(s)
Beleodaq is indicated for the treatment of patients with relapsed or refractory peripheral T-cell lymphoma (PTCL).

This indication is approved under accelerated approval based on tumor response rate and duration of response. An improvement in survival or disease-related symptoms has not been established. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trial.

Policy/Criteria
It is the policy of PA Health & Wellness ® that Beleodaq is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Peripheral T-Cell Lymphoma (must meet all):
1. Diagnosis of PTCL – (*see Appendix D for examples of PTCL subtypes*);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. One of the following (a or b):
   a. Prescribed as initial palliative intent therapy;
   b. Failure of at least one prior therapy (*see Appendix B for examples*);*
   **Prior authorization may be required for prior therapies*
5. Prescribed as a single agent;
6. Request meets one of the following (a or b):
   a. Dose does not exceed 1,000/mg/m^2 per day on days 1-5 of a 21-day cycle;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

B. NCCN-Recommended Off-Label Indications (must meet all)**:**
1. Diagnosis of one of the following (a, b, c or d):
   a. Adult T-cell leukemia/lymphoma after failure of first-line therapy (*see Appendix B for examples*);
   b. Extranodal NK/T-cell lymphoma following asparaginase-based therapy (*see Appendix B for examples*);
   c. Hepatosplenic T-cell lymphoma after failure of 2 prior treatment regimens (*see Appendix B for examples*);

d. Breast implant associated anaplastic large cell lymphoma after failure of first-line therapy (*see Appendix B for examples*);

2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Prescribed as a single agent;
5. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

C. Other diagnoses/indications: Refer to PA.CP.PMN.53

II. Continued Approval

A. All Indications in Section I (must meet all)**:**

1. Currently receiving medication via PA Health & Wellness benefit or member has previously met all initial approval criteria; or the Continuity of Care policy (PA.PHARM.01) applies;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):
   a. New dose does not exceed 1,000/mg/m^2 per day on days 1-5 of a 21-day cycle;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy; or the Continuity of Care policy (PA.PHARM.01) applies; or
2. Refer to PA.CP.PMN.53

III. Diagnoses/Indications for which coverage is NOT authorized

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies –PA.CP.PMN.53

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
NCCN: National Comprehensive Cancer Network
PTCL: peripheral T-cell lymphoma

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
PTCL - examples of first-line and subsequent therapy: • Brentuximab vedotin + CHP (cyclophosphamide, doxorubicin, and prednisone) • CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, prednisone) • CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) • Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin) • DHAP (dexamethasone, cisplatin, cytarabine) • ESHAP (etoposide, methylprednisolone, cytarabine, cisplatin)	Varies	Varies
Adult T-cell leukemia/lymphoma - examples of first-line therapy: • Brentuximab vedotin + CHP (cyclophosphamide, doxorubicin, and prednisone) • CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, prednisone) • CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) • Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin) • HyperCVAD (cyclophosphamide, vincristine, doxorubicin, dexamethasone) alternating with high-dose methotrexate and cytarabine	Varies	Varies
Extranodal NK/T-cell lymphoma - examples of asparaginase-based therapy: • AspaMetDex (pegaspargase, methotrexate, dexamethasone) • DDGP (dexamethasone, cisplatin, gemcitabine, pegaspargase) • Modified-SMILE (steroid, methorexate, ifosfamide, pegaspargase, etoposide) • P-GEMOX (gemcitabine, pegaspargase, oxaliplatin)	Varies	Varies
Hepatosplenic T-cell lymphoma - examples of first-line therapy (for subsequent therapy examples see PTCL): • ICE (ifosfamide, carboplatin, etoposide) • CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, prednisone) • Brentuximab vedotin + CHP (cyclophosphamide, doxorubicin, and prednisone)	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Breast implant-associated anaplastic large cell lymphoma - examples of first-line therapy: • Brentuximab vedotin • Brentuximab vedotin + CHP (cyclophosphamide, doxorubicin, and prednisone) • CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) • CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, prednisone) • Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin)	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information
- PTCL - subtypes/histologies:
  - PTCL, not otherwise specified;
  - Anaplastic large cell lymphoma;
  - Angioimmunoblastic T-cell lymphoma;
  - Enteropathy-associated T-cell lymphoma;
  - Monomorphic epitheliotropic intestinal T-cell lymphoma;
  - Nodal peripheral T-cell lymphoma with TFH phenotype;
  - Follicular T-cell lymphoma;

**PTLC is classified as a non-Hodgkin T-cell lymphoma. PTCL classification schemes are periodically advanced as new information becomes available; therefore, the above list is provided as general guidance. For additional information, see WHO's 2016 updated classification of hematological malignancies for a complete list of lymphoid neoplasms, including PTCL.*

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PTCL	1,000 mg/m^2 IV on days 1-5 of a 21-day cycle. Cycles can be repeated every 21 days until disease progression or unacceptable toxicity.	1,000 mg/m^2/day

VI. Product Availability
Single-dose vial: 500 mg

VII. References

1. Beleodaq Prescribing Information. Irvine, CA: Spectrum Pharmaceuticals, Inc.; May 2023. Available at: http://www.beleodaq.com/ . Accessed Accessed July 17, 2024.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed August 5, 2024.
3. National Comprehensive Cancer Network. T-Cell Lymphomas Version 4.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/t-cell.pdf. Accessed August 7, 2024.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9032	Injection, belinostat, 10 mg

Reviews, Revisions, and Approvals	Date
4Q 2018 annual review: no significant changes; summarized NCCN and FDA-approved uses for improved clarity; added specialist involvement in care; references reviewed and updated.	07/2018
4Q 2019 annual review: No changes per Statewide PDL implementation 01-01-2020	10/2019
4Q 2020 annual review: added NCCN-recommended (with Category 2A or above) off-label uses: extranodal NK/T-cell lymphoma, nasal type, hepatosplenic gamma-delta T-cell lymphoma; added additional off-label indication cutaneous CD30+ T-cell lymphoma as per NCCN 2A or above off label indication; added Appendix D: PTCL subtypes per NCCN; references reviewed and updated.	10/2020
4Q 2021 annual review: references reviewed and updated.	10/2021
4Q 2022 annual review: updated NCCN-recommended off-label uses: removed mycosis fungoides, cutaneous CD30+ T-cell lymphoma, and Sézary syndrome; added breast implant ALCL (Category 2A recommendation); references reviewed and updated.	10/2022
4Q 2023 annual review: no significant changes; references reviewed and updated.	10/2023
4Q 2024 annual review: per NCCN, added that Beleodaq must be prescribed as a single agent and added requirements regarding prior therapies (with bypass allowed if prescribed as palliative therapy for PTCL); removed primary cutaneous ALCL as a coverable off-label use as it is no longer recommended by NCCN; references reviewed and updated.	10/2024