# Clinical Policy: Belinostat (Beleodaq)

Reference Number: CP.PHAR.311
Effective Date: 02.01.17
Last Review Date: 11.24
Line of Business: HIM, Medicaid

Coding Implications
Revision Log

**See Important Reminder at the end of this policy for important regulatory and legal information.**

## Description

Belinostat (Beleodaq®) is a histone deacetylase inhibitor.

## FDA Approved Indication(s)

Beleodaq is indicated for the treatment of adult 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

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation® 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*).
   **Prescribed regimen must be FDA-approved or recommended by NCCN*

**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, nasal type 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*).*

**Prescribed regimen must be FDA-approved or recommended by NCCN*

**Approval duration: 6 months**

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid.

## II. Continued Therapy

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

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Beleodaq for a covered indication and has received this medication for at least 30 days;
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*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

**Approval duration: 12 months**

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid.

## 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 – HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid, or evidence of coverage documents.

## 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 for all relevant lines of business and may require prior authorization.*

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| PTCL - examples of first-line and subsequent therapy:<br>• Brentuximab vedotin + CHP (cyclophosphamide, doxorubicin, and prednisone)<br>• CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, prednisone)<br>• CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone)<br>• Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin)<br>• DHAP (dexamethasone, cisplatin, cytarabine) | Varies | Varies |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| • ESHAP (etoposide, methylprednisolone, cytarabine, cisplatin) | | |
| Adult T-cell leukemia/lymphoma - examples of first-line therapy:<br>• Brentuximab vedotin + CHP (cyclophosphamide, doxorubicin, and prednisone)<br>• CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, prednisone)<br>• CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone)<br>• Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin)<br>• HyperCVAD (cyclophosphamide, vincristine, doxorubicin, dexamethasone) alternating with high-dose methotrexate and cytarabine | Varies | Varies |
| Extranodal NK/T-cell lymphoma - examples of asparaginase-based therapy:<br>• AspaMetDex (pegaspargase, methotrexate, dexamethasone)<br>• DDGP (dexamethasone, cisplatin, gemcitabine, pegaspargase)<br>• Modified-SMILE (steroid, methorexate, ifosfamide, pegaspargase, etoposide)<br>• P-GEMOX (gemcitabine, pegaspargase, oxaliplatin) | Varies | Varies |
| Hepatosplenic T-cell lymphoma - examples of first-line therapy (for subsequent therapy examples see PTCL):<br>• ICE (ifosfamide, carboplatin, etoposide)<br>• CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, prednisone)<br>• Brentuximab vedotin + CHP (cyclophosphamide, doxorubicin, and prednisone) | Varies | Varies |
| Breast implant-associated anaplastic large cell lymphoma - examples of first-line therapy:<br>• Brentuximab vedotin<br>• Brentuximab vedotin + CHP (cyclophosphamide, doxorubicin, and prednisone)<br>• CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone)<br>• CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, prednisone)<br>• 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. East Windsor, NJ: Acrotech Biopharma Inc.; May 2023. Available at: https://beleodaq.com. Accessed July 17, 2024.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. 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 | P&T Approval Date |
|---|---|---|
| 4Q 2020 annual review: modified HIM-Medical Benefit to HIM line of business; 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. | 08.14.20 | 11.20 |
| 4Q 2021 annual review: HIM.PHAR.21 changed to HIM.PA.154; references reviewed and updated. | 06.30.21 | 11.21 |
| 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. Template changes applied to other diagnoses/indications. | 07.05.22 | 11.22 |
| 4Q 2023 annual review: no significant changes; references reviewed and updated. | 08.14.23 | 11.23 |
| 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; removed "gamma delta" qualifier from hepatosplenic T-cell lymphoma as NCCN does not specify this; references reviewed and updated. | 08.07.24 | 11.24 |

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.