



Medical Policy Manual **Approved Rev: Do Not Implement until 7/31/26**

Bortezomib (Velcade®; Bortezomib, Boruzu™)

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

POLICY

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.

FDA-Approved Indications

- Treatment of adult patients with multiple myeloma
- Treatment of adult patients with mantle cell lymphoma

Compendial Uses

- Systemic light chain amyloidosis
- Waldenström macroglobulinemia/lymphoplasmacytic lymphoma
- Multicentric Castleman disease
- Adult T-cell leukemia/lymphoma
- Antibody mediated rejection of solid organ
- Acute lymphoblastic leukemia
- Follicular lymphoma
- Kaposi sarcoma
- Pediatric classic Hodgkin lymphoma
- POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome
- Plasma cell-related Monoclonal Immunoglobulin Deposition Disease (MIDD)
- Plasma cell-related Monoclonal Gammopathy of Renal Significance (MGRS)

All other indications are considered experimental/investigational and not medically necessary.

COVERAGE CRITERIA

Multiple Myeloma

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

Mantle Cell Lymphoma

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

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Multicentric Castleman Disease

Authorization of 12 months may be granted for the treatment of multicentric Castleman disease as subsequent therapy.

Systemic Light Chain Amyloidosis

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

Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma

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

Adult T-Cell Leukemia/Lymphoma

Authorization of 12 months may be granted for the treatment of adult T-cell leukemia/lymphoma when the requested medication will be used as a single agent for subsequent therapy.

Antibody Mediated Rejection of Solid Organ

Authorization of 12 months may be granted for the treatment of antibody mediated rejection of solid organ.

Acute Lymphoblastic Leukemia

Authorization of 12 months may be granted for the treatment of acute lymphoblastic leukemia.

Follicular Lymphoma

Authorization of 12 months may be granted for the treatment of relapsed or refractory follicular lymphoma.

Kaposi Sarcoma

Authorization of 12 months may be granted for the treatment of Kaposi sarcoma as subsequent therapy.

Pediatric Classic Hodgkin Lymphoma

Authorization of 12 months may be granted for the treatment of relapsed or refractory pediatric classic Hodgkin lymphoma.

POEMS (Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal Protein, Skin Changes) Syndrome, plasma cell-related Monoclonal Immunoglobulin Deposition Disease (MIDD), plasma cell-related Monoclonal Gammopathy of Renal Significance (MGRS)

Authorization of 12 months may be granted for treatment of POEMS syndrome, plasma cell-related MIDD, or plasma cell-related MGRS.

DOSAGE AND ADMINISTRATION

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Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

For all indications, dosing does not exceed 1.6 mg/m² per dose and does not require more than 7 doses per 30-day period.

CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

REFERENCES

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