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| **Clinical Policy Title:** | panobinostat |
| **Policy Number:** | RxA.127 |
| **Drug(s) Applied:** | Farydak® |
| **Original Policy Date:** | 03/06/2020 |
| **Last Review Date:** | 08/28/2024 |
| **Line of Business Policy Applies to:** | All lines of business (except Medicare) |

## Criteria

**I. Initial Approval Criteria**

**A. Multiple Myeloma** (must meet all)**:**

1. Diagnosis of multiple myeloma;
2. Trial and failure of at least two (2) prior regimens for multiple myeloma, including bortezomib and an immunomodulatory agent (e.g., dexamethasone), unless contraindicated or clinically significant adverse effects are experienced;
3. Used in combination with bortezomib and dexamethasone.
   *Prior authorization may be required for these agents

**Approval duration**

**All Lines of Business (except Medicare):** 6 months

**II. Continued Therapy**

**A. Multiple Myeloma** (must meet all)**:**

1. Auto-approval is based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

**Approval duration**

**All Lines of Business (except Medicare):** 12 months

**References**

Not applicable.

| Review/Revision History | Review/Revised Date | P&T Approval Date |
|---|---|---|
| Policy was established | 02/2020 | 03/06/2020 |
| Policy was reviewed<br>Policy changes:<br>1. Policy title table was updated.<br>2. Line of business policy applies was updated to All lines of business<br>3. Continued therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance…."<br>4. Updated the approval length for Commercial line | 09/10/2020 | 12/07/2020 |

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| of business from length of benefit to 6 months for initial and 12 months for continuation therapy. | | |
| Policy was reviewed:<br>1. Initial Approval Criteria I.A.5.b, I.A.5.c, and I.A.7 were updated to include “off-label...”<br>2. Continued Therapy Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". | 05/28/2021 | 09/14/2021 |
| Policy was reviewed:<br>1. Initial Approval Criteria I.5: Updated from 5. Used in combination with one of the following (a, b, or c):* a. bortezomib and dexamethasone; b. carfilzomib (Kyprolis®) (off-label), or c. lenalidomide (Revlimid®) anddexamethasone (off-label); to Used in combination with bortezomib and dexamethasone. | 02/02/2022 | 04/18/2022 |
| Policy was reviewed. | 10/28/2022 | 01/17/2023 |
| Policy was reviewed. | 10/19/2023 | 10/19/2023 |
| Policy was reviewed:<br>1. Removed age restrictions.<br>2. Removed prescriber restrictions.<br>3. Removed dose restrictions.<br>4. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days.<br>5. Removed other reauthorization requirements including positive response to therapy.<br>6. Updated approval duration verbiage. | 08/28/2024 | 09/13/2024 |