Clinical Policy: Carfilzomib (Kyprolis)

Reference Number: CP.PHAR.309
Effective Date: 02.01.17
Last Review Date: 11.25
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

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

Description

Carfilzomib (Kyprolis®) is a proteasome inhibitor.

FDA Approved Indication(s)

Kyprolis is indicated

- For the treatment of adult patients with relapsed or refractory multiple myeloma (MM) who have received one to three lines of therapy in combination with:
  - Lenalidomide and dexamethasone or
  - Dexamethasone or
  - Daratumumab and dexamethasone or
  - Daratumumab and hyaluronidase-fihj and dexamethasone or
  - Isatuximab and dexamethasone
- As a single agent for the treatment of adult patients with relapsed or refractory MM who have received one or more lines of therapy.

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 Kyprolis is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of MM;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. For relapsed or refractory disease, one of the following (a or b):
   a. Member has measurable disease as evidenced by one of the following assessed within the last 30 days (i, ii, or iii):
      i. Serum M-protein ≥ 0.5 g/dL;
      ii. Urine M-protein ≥ 200 mg/24 h;
      iii. Serum free light chain (FLC) assay: involved FLC level ≥ 10 mg/dL (100 mg/L) provided serum FLC ratio is abnormal;
   b. Member has progressive disease, as defined by the IMWG response criteria (see *Appendix D*), assessed within 60 days following the last dose of the last anti-myeloma drug regimen received;

5. For primary therapy, Kyprolis is prescribed in one of the following ways (a, b, or c):*
   a. In combination with dexamethasone and lenalidomide;
   b. In combination with dexamethasone and cyclophosphamide;
   c. In combination with dexamethasone, lenalidomide, and Darzalex® (daratumumab);
   d. In combination with dexamethasone, lenalidomide, and Sarclisa® (isatuximab-irfc);

   **Prior authorization may be required.*
6. For maintenance therapy, Kyprolis is prescribed in combination with lenalidomide;
7. For previously treated multiple myeloma for relapsed or refractory disease, Kyprolis is prescribed in one of the following ways (a - i):*
   a. In combination with dexamethasone or with lenalidomide plus dexamethasone in patients who have received one to three lines of therapy *(see Appendix B for examples of prior therapy)*;
   b. As a single agent in patients who have received one or more lines of therapy;
   c. In combination with Darzalex (daratumumab) or Darzalex Faspro® (daratumumab/hyaluronidase-fihj) and dexamethasone in patients who have received one to three lines of therapy;
   d. In combination with Sarclisa (isatuximab-irfc) and dexamethasone in patients who have received one to three lines of therapy;
   e. In combination with Xpovio (selinexor) and dexamethasone in patients who have received one to three lines of therapy;
   f. In combination with dexamethasone and cyclophosphamide, with or without thalidomide, in patients who have received one to three lines of therapy;
   g. In combination with pomalidomide and dexamethasone ± Darzalex (daratumumab) in patients who have received one to three lines of therapy;
   h. In combination with venetoclax and dexamethasone in patients with t(11:14) translocations who received one to three lines of therapy;
   i. In combination with bendamustine and dexamethasone for patients with late relapse or progressive disease who have failed at least three prior therapies;

   **Prior authorization may be required.*
8. Request meets one of the following (a, b, c, d, or e):*
   a. Monotherapy: dose does not exceed 56 mg/m^2 twice weekly each 28-day cycle;
   b. With dexamethasone and lenalidomide: dose does not exceed 27 mg/m^2 twice weekly 3 out of 4 weeks for twelve 28-day cycles, then 27 mg/m^2 twice weekly 2 out of 4 weeks for the next six 28-day cycles for up to a total of 18 cycles;
   c. With dexamethasone ± Darzalex: dose does not exceed (i or ii):
      i. 70 mg/m^2 once weekly each 28-day cycle;
      ii. 56 mg/m^2 twice weekly each 28-day cycle;
   d. With dexamethasone and Sarclisa: 56 mg/m^2 twice weekly each 28-day cycle;
   e. 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:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Waldenstrom's Macroglobulinemia (Lymphoplasmacytic Lymphoma) (off-label) (must meet all)**:**
1. Diagnosis of Waldenstrom's macroglobulinemia (i.e., lymphoplasmacytic lymphoma) (WM/LPL);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed as a component of CaRD (carfilzomib, rituximab*, and dexamethasone) regimen as primary or Kyprolis-relapsed therapy;
   **Prior authorization may be required.*
5. 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:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

C. Systemic Light Chain Amyloidosis (off-label) (must meet all)**:**
1. Diagnosis of systemic light chain amyloidosis;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Request is for one of the following (a or b):
   a. Newly diagnosed disease;
   b. Relapsed/refractory as a repeat of initial therapy if relapse-free for several years;
   c. Relapsed/refractory non-cardiac disease;
5. Prescribed in one of the following ways (a or b):
   a. As a single agent;
   b. In combination with dexamethasone;
6. 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:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

D. 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: CP.CPA.190 for commercial, 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: CP.CPA.190 for commercial, 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: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

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

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Kyprolis 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, b, c, d, or e):*
   a. Monotherapy: new dose does not exceed 56 mg/m^2 twice weekly each 28-day cycle;
   b. With dexamethasone and lenalidomide: new dose does not exceed 27 mg/m^2 twice weekly 3 out of 4 weeks for twelve 28-day cycles, then 27 mg/m^2 twice weekly 2 out of 4 weeks for the next six 28-day cycles for up to a total of 18 cycles;
   c. With dexamethasone ± Darzalex: new does not exceed (i or ii):
      i. 70 mg/m^2 once weekly each 28-day cycle;
      ii. 56 mg/m^2 twice weekly each 28-day cycle;
   d. With dexamethasone and Sarclisa: 56 mg/m^2 twice weekly each 28-day cycle;
   e. 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:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Waldenstrom's Macroglobulinemia (Lymphoplasmacytic Lymphoma) (off-label) (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Kyprolis for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. 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:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

C. Systemic Light Chain Amyloidosis (off-label) (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Kyprolis for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;

3. 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:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

D. 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: CP.CPA.190 for commercial, 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: CP.CPA.190 for commercial, 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: CP.CPA.09 for commercial, 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 – CP.CPA.09 for commercial, 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

CaRD: carfilzomib, rituximab, dexamethasone
FDA: Food and Drug Administration
FLC: free light chain
IMWG: International Myeloma Working Group
MM: multiple myeloma
NCCN: National Comprehensive Cancer Network
WM/LPL: Waldenstrom's macroglobulinemia/lymphoplasmacytic 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
Kyprolis (carfilzomib), bortezomib (Velcade®), lenalidomide (Revlimid), cyclophosphamide, dexamethasone	MM: Examples of primary therapy • Bortezomib/dexamethasone • Bortezomib/lenalidomide/dexamethasone • Bortezomib/cyclophosphamide/dexamethasone • Bortezomib/doxorubicin/dexamethasone • Bortezomib/thalidomide/dexamethasone • Carfilzomib/cyclophosphamide/dexamethasone • Carfilzomib/lenalidomide/dexamethasone • Cyclophosphamide/lenalidomide/dexamethasone • Daratumumab/lenalidomide/dexamethasone • Daratumumab/lenalidomide/bortezomib/ dexamethasone • Daratumumab/carfilzomib/lenalidomide/ dexamethasone • Daratumumab/cyclophosphamide/bortezomib/ dexamethasone • Daratumumab/bortezomib/thalidomide/ dexamethasone • Daratumumab/bortezomib/melphalan/prednisone • Dexamethasone/thalidomide/cisplatin/doxorubicin/ cyclophosphamide/etoposide/bortezomib (VTD-PACE) • Ixazomib/cyclophosphamide/dexamethasone • Ixazomib/lenalidomide/dexamethasone • Lenalidomide/low-dose dexamethasone	Varies
Kyprolis (carfilzomib), bortezomib (Velcade), lenalidomide (Revlimid), Darzalex® (daratumumab), Ninlaro® (ixazomib), Pomalyst (pomalidomide), Empliciti® (elotuzumab), Thalomid® (thalidomide),	MM: Examples of therapy for previously treated for relapsed or refractory disease: • Bendamustine • Bendamustine/bortezomib/dexamethasone • Bendamustine/lenalidomide/dexamethasone • Bendamustine/carfilzomib/dexamethasone • Bortezomib/dexamethasone • Bortezomib/lenalidomide/dexamethasone • Bortezomib/liposomal doxorubicin/dexamethasone • Bortezomib/cyclophosphamide/dexamethasone • Carfilzomib/cyclophosphamide/dexamethasone • Carfilzomib/dexamethasone • Carfilzomib/lenalidomide/dexamethasone • Carfilzomib/cyclophosphamide/dexamethasone	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
bendamustine, cyclophosphamide, dexamethasone, Sarclisa® (istatuximab-irfc), Xpovio® (selinexor)	• Carfilzomib/cyclophosphamide/thalidomide/ dexamethasone • Cyclophosphamide/lenalidomide/dexamethasone • Cyclophosphamide • Daratumumab • Daratumumab/bortezomib/dexamethasone • Daratumumab/carfilzomib/dexamethasone • Daratumumab/cyclophosphamide/bortezomib/ dexamethasone • Daratumumab/lenalidomide/dexamethasone • Daratumumab/pomalidomide/dexamethasone • Dexamethasone/cyclophosphamide/etoposide/cisplatin • Dexamethasone/thalidomide/cisplatin/doxorubicin/ cyclophosphamide/etoposide/ +/- bortezomib • Elotuzumab/lenalidomide/dexamethasone • Elotuzumab/bortezomib/dexamethasone • Elotuzumab/pomalidomide/dexamethasone • Istatuximab-irfc/carfilzomib/dexamethasone • Ixazomib/cyclophosphamide/dexamethasone • Ixazomib/lenalidomide/dexamethasone • Ixazomib/pomalidomide/desamethasone • Isatuximab-irfc/pomalidomide/dexamethasone • Lenalidomide/dexamethasone Pomalidomide/bortezomib/dexamethasone • Pomalidomide/carfilzomib/dexamethasone • Pomalidomide/cyclophosphamide/dexamethasone • Pomalidomide/dexamethasone • Selinexor/bortezomib/dexamethasone • Selinexor/carfilzomib/dexamethasone • Selinexor/daratumumab/dexamethasone • Selinexor/opomalidomide/dexamthasone • Venetoclax/dexamethasone • Ideocabtagene vicleucel • Ciltacabtagene autoleucel • Teclistamab-cqyv • Benlantamab mafodotin-blmf	
rituximab (Rituxan®), Kyprolis (carfilzomib)	WM/LPL: CaRD (carfilzomib, rituximab, and dexamethasone)	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
dexamethasone		

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/Black Box Warnings
None reported

Appendix D: General Information
- The IMWG response criteria for multiple myeloma definition of progressive disease requires only one of the following:
  - Increase of 25% from lowest response value in any of the following:
    - Serum M-component (absolute increase must be ≥ 0.5 g/dL), and/or
    - Urine M-component (absolute increase must be ≥ 200 mg/24 h), and/or
  - Only in patients without measurable serum and urine M-protein levels: the difference between involved and uninvolved FLC levels (absolute increase must be > 10 mg/dL)
  - Only in patients without measurable serum and urine M protein levels and without measurable disease by FLC levels, bone marrow plasma cell percentage irrespective of baseline status (absolute increase must be ≥ 10%)
  - Appearance of a new lesion(s), ≥ 50% increase from nadir in SPD (sum of the products of the maximal perpendicular diameters of measured lesions) of > 1 lesion, or ≥ 50% increase in the longest diameter of a previous lesion >1 cm in short axis;
  - ≥ 50% increase in circulating plasma cells (minimum of 200 cells per µL) if this is the only measure of disease

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose

MM	<u>Kyprolis + Dexamethasone:</u>
	• Cycles: Kyprolis IV as a 30-minute infusion (28-day cycles).
	  ○ Cycle 1: administer Kyprolis 20 mg/m^2 on Day 1 and 70 mg/m^2 on Days 8 and 15
	  ○ Cycle 2 and later: 70 mg/m^2 on Day 1, 8, and 15
	• Dose (once weekly 20/70 mg/m^2 regimen):
	  ○ Starting dose of Kyprolis 20 mg/m^2 on Cycle 1, Day 1
	  ○ If tolerated, escalate Kyprolis to 70 mg/m^2 on Day 8 of Cycle 1.
	  ○ Dexamethasone: 40 mg PO or IV on Days 1, 8, 15 of all 28-day cycles and on Day 22 of Cycles 1-9.
	
	<u>Kyprolis + Dexamethasone, OR **Monotherapy**:</u>
		70 mg/m^2

Indication	Dosing Regimen	Maximum Dose

	• Cycles: Kyprolis IV as a 30-minute infusion (28-day cycles).
	  ○ Cycle 1: administer Kyprolis 20 mg/m^2 on Days 1 and 2, and 56 mg/m^2 on Day 8, 9, 15, and 16
	  ○ Cycle 2 and later: administer Kyprolis 56 mg/m^2 on Days 1, 2, 8, 9, 15 and 16
	  ○ For monotherapy: Cycle 13 and later: administer Kyprolis 56 mg/m^2 on Days 1, 2, 15 and 16
	• Dose (twice weekly 20/56 mg/m^2 regimen):
	  ○ Starting dose of Kyprolis 20 mg/m^2 on Cycle 1, Days 1 and 2
	  ○ If tolerated, escalate Kyprolis to 56 mg/m^2 on Day 8 of Cycle 1.
	Do not include if Monotherapy:
	  ○ Dexamethasone: 20 mg PO or IV on Days 1, 2, 8, 9, 15, 16, 22 and 23 of each 28-day cycle.
	
	Kyprolis + lenalidomide + Dexamethasone, OR **Monotherapy**:
	• Cycles: Kyprolis IV as a 10-minute infusion for 28-day cycles.
	  ○ Cycle 1: administer Kyprolis 20 mg/m^2 on Days 1 and 2, and 27 mg/m^2 on Days 8, 9, 15 and 16
	  ○ Cycle 2 to 12: administer Kyprolis 27 mg/m^2 on Days 1, 2, 8, 9, 15 and 16
	  ○ Cycle 13 and later, administer Kyprolis 27mg/m^2 on Day 1, 2, 15 and 16
	  ○ Discontinue Kyprolis after Cycle 18 and continue lenalidomide and dexamethasone thereafter.
	• Dose (twice weekly 20/27 mg/m^2 regimen):
	  ○ Starting dose of Kyprolis: 20 mg/m^2 on Cycle 1, Days 1 and 2
	  ○ If tolerated, escalate Kyprolis to 27 mg/m^2 on Day 8 of Cycle 1.
	Do not include if Monotherapy:
	  ○ Lenalidomide: 25 mg PO QD on Days 1–21 of each cycle.
	  ○ Dexamethasone: 40 mg PO or IV on Days 1, 8, 15, and 22 of each 28-day cycle.
	
	Kyprolis + Darzalex + Dexamethasone:
	Twice weekly 20/56 mg/m^2 regimen:
	• Cycles: Kyprolis IV as a 30-minute infusion (28-day cycles).	

Indication	Dosing Regimen	Maximum Dose
	○ Cycle 1: administer Kyprolis 20 mg/m^2 on Days 1 and 2 and 56 mg/m^2 on Days 8, 9, 15 and 16 ○ Cycle 2 and later: administer Kyprolis 56 mg/m^2 on Days 1, 2, 8, 9, 15 and 16 • Dose: ○ Starting dose of Kyprolis: 20 mg/m^2 on Cycle 1, Days 1 and 2 ○ If tolerated, escalate Kyprolis to 56 mg/m^2 on Day 8 of Cycle 1 ○ See prescribing information for Darzalex, Darzalex Faspro, and dexamethasone dosing. Once weekly 20/70 mg/m^2 regimen: • Cycles: Kyprolis IV as a 30-minute infusion (28-day cycles). ○ Cycle 1: administer Kyprolis 20 mg/m^2 on Day 1 and 70 mg/m^2 on Days 8 and 15 ○ Cycle 2 and later: administer Kyprolis 70 mg/m^2 on Days 1, 8 and 15 • Dose: ○ Starting dose of Kyprolis: 20 mg/m^2 on Cycle 1, Days 1 and 2 ○ If tolerated, escalate Kyprolis to 70 mg/m^2 on Day 8 of Cycle 1 ○ See prescribing information for Darzalex, Darzalex Faspro, and dexamethasone dosing. <u>Kyprolis + Sarclisa + Dexamethasone:</u> Twice weekly 20/56 mg/m^2 regimen: • Cycles: Kyprolis IV as a 30-minute infusion (28-day cycles). ○ Cycle 1: administer Kyprolis 20 mg/m^2 on Days 1 and 2 and 56 mg/m^2 on Days 8, 9, 15 and 16 ○ Cycle 2 and later: administer Kyprolis 56 mg/m^2 on Days 1, 2, 8, 9, 15 and 16 • Dose: ○ Starting dose of Kyprolis: 20 mg/m^2 on Cycle 1, Days 1 and 2 ○ If tolerated, escalate Kyprolis to 56 mg/m^2 on Day 8 of Cycle 1 ○ See prescribing information for Sarclisa dosing. _____ *Calculate the Kyprolis dose using the patient's actual body surface area at baseline. In patients with a body surface area greater than 2.2 m^2, calculate the dose based upon a body surface area of 2.2 m^2.*	

VI. Product Availability

Single-dose vials: 10 mg, 30 mg, 60 mg

VII. References

1. Kyprolis Prescribing Information. Thousand Oaks: Onyx Pharmaceuticals, Inc.; June 2025. Available at: https://www.pi.amgen.com/-/media/Project/Amgen/Repository/pi-amgen-com/Kyprolis/kyprolis_pi.pdf. Accessed July 09,2025.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed August 28, 2025.
3. National Comprehensive Cancer Network. Multiple Myeloma Version 02.2026 Available at: https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf. Accessed August 28, 2025.
4. National Comprehensive Cancer Network. Waldenstrom's macroglobulinemia-lymphoplasmacytic lymphoma Version 01.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/waldenstroms.pdf. Accessed August 28, 2025.
5. National Comprehensive Cancer Network. Systemic Light Chain Amyloidosis Version 1.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/amyloidosis.pdf. Accessed August 28, 2025.

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
J9047	Injection, carfilzomib, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2021 annual review: added primary therapy and revised therapy for previous treated for relapsed or refractory disease and updated Appendix B Therapeutic Alternatives as per NCCN recommendation; updated Section V Dosage and Administration and Section VI Product Availability; modified reference from HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	08.06.21	11.21
4Q 2022 annual review: RT4 – added new indication in combination with Sarclisa plus dexamethasone and Darzalex Faspro plus dexamethasone for MM after one to three lines of therapy; per NCCN Compendium added additional MM uses as primary therapy in combination with dexamethasone, lenalidomide, and Darzalex, added previously treated MM combination regimens, added criteria	07.12.22	11.22

Reviews, Revisions, and Approvals	Date	P&T Approval Date
set for systemic light chain amyloidosis; references reviewed and updated. Template changes applied to other diagnoses/indications.		
4Q 2023 annual review: updated MM initial approval criteria to include "for maintenance therapy, Kyprolis is prescribed in combination with lenalidomide" and "in combination with bendamustine and dexamethasone for patients with late relapse or progressive disease who have failed at least three prior therapies" to align with current NCCN compendium and MM guidelines; for Appendix B, updated section with current MM primary therapies and previously treated for relapsed or refractory therapies per current MM guidelines version 3.2023 and removed Panobinostat regimens as agent was withdrawn from market; references reviewed and updated.	08.06.23	11.23
4Q 2024 annual review: for relapse or refractory multiple myeloma prescribing regimens: added hematologist as prescriber option, added IMWG criterion defining progressive MM disease as MM class alignment, revised verbiage from "one or three lines of therapy" to "one to three lines of therapy", added verbiage "in patients who have received one to three lines of therapy" when used in combination with Xpovio, cyclophosphamide, or pomalidomide; added regimen option in combination with venetoclax and dexamethasone in patients with t(11:14) translocations; for systemic light chain amyloidosis, added option for treatment for newly diagnosed disease or relapsed/refractory disease as a repeat of initial therapy if relapse-free for several years per NCCN; for Commercial line of business, revised approval duration to standard language of "6 months or to the member's renewal date, whichever is longer"; references reviewed and updated.	07.15.24	11.24
4Q 2025 annual review: for MM primary treatment, added option to be prescribed in combination with Sarclisa per NCCN; initial approval durations changed from 6 to 12 months for Medicaid/HIM; references reviewed and updated.	07.09.25	11.25

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.