

Clinical Policy Title:	panobinostat
Policy Number:	RxA.127
Drug(s) Applied:	Farydak®
Original Policy Date:	03/06/2020
Last Review Date:	12/11/2025
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 Policy changes: 1. Policy title table was updated. 2. Line of business policy applies was updated to All lines of business 3. Continued therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance...." 4. Updated the approval length for Commercial line	09/10/2020	12/07/2020

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

of business from length of benefit to 6 months for initial and 12 months for continuation therapy.		
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> 1. Initial Approval Criteria I.A.5.b, I.A.5.c, and I.A.7 were updated to include “off-label...” 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
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> 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®) and dexamethasone (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
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> 1. Removed age restrictions. 2. Removed prescriber restrictions. 3. Removed dose restrictions. 4. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days. 5. Removed other reauthorization requirements including positive response to therapy. 6. Updated approval duration verbiage. 	08/28/2024	09/13/2024
Policy was reviewed.	12/05/2024	N/A
Policy reviewed.	12/11/2025	12/11/2025