Bendamustine Agents (Belrapzo, Bendeka, Treanda, Vivimusta)

Override(s)	Approval Duration
Prior Authorization	1 year

Medications
Belrapzo (bendamustine hydrochloride) Bendeka (bendamustine hydrochloride) Treanda (bendamustine hydrochloride) Vivimusta (bendamustine hydrochloride)

APPROVAL CRITERIA

Requests for bendamustine agents (Belrapzo, Bendeka, Treanda, Vivimusta) may be approved if the following criteria are met:

I. Individual has a diagnosis of one of the following:
   A. Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL); **OR**
   B. Relapsed, refractory or progressive classical Hodgkin lymphoma (NCCN 2A); **OR**
   C. Non-Hodgkin lymphoma (NHL); **OR**
   D. Relapsed, refractory, or progressive Multiple myeloma (NCCN 2A); **OR**
   E. Relapsed or refractory systemic light chain amyloidosis; **OR**
   F. Waldenström's macroglobulinemia (NCCN 2A); **OR**
   G. Cold agglutinin disease (DP BIIa; Jager 2020).

Requests for bendamustine agents (Belrapzo, Bendeka, Treanda, Vivimusta) may not be approved for the following:

I. Treatment of metastatic breast cancer; **OR**
II. Treatment of small cell lung cancer (SCLC); **OR**
III. When the above criteria are not met and for all other indications.

Key References:

1. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed: January 5, 2024.
2. DrugPoints® System [electronic version]. Truven Health Analytics, Greenwood Village, CO. Updated periodically.
3. Jager U, Barcellini W, Broome C, et al. Diagnosis and treatment of autoimmune hemolytic anemia in adults: Recommendations from the first International Consensus meeting. Blood Rev. 2020; 41:100648.
4. Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2024; Updated periodically.
5. NCCN Clinical Practice Guidelines in Oncology™. © 2024 National Comprehensive Cancer Network, Inc. For additional information visit the NCCN website: http://www.nccn.org/index.asp. Accessed January 2024.
   a. Chronic Lymphocytic leukemia/small lymphocytic lymphoma. V1.2024. Revised November 3, 2023.
   b. B-Cell Lymphomas. V6.2023. Revised October 10, 2023.

c. T-Cell Lymphomas. V1.2023. Revised January 5, 2023.
d. Waldenstrom Macroglobulinemia/Lymphoplasmacytic lymphoma. V2.2024. Revised December 5, 2023.
e. Multiple Myeloma. V2.2024. Revised November 1, 2023.
f. Hodgkin Lymphoma. V1.2024. Revised October 12, 2023.
g. Pediatric Hodgkin Lymphoma. V2.2023. Revised March 9, 2023.
h. Systemic Light Chain Amyloidosis. V2.2024. Revised December 12, 2023.
i. Hematopoietic Cell Transplantation (HCT). V3.2023. Revised October 9, 2023.

Federal and state laws or requirements, contract language, and Plan utilization management programs or polices may take precedence over the application of this clinical criteria.