I. Medication Description

Bortezomib is a reversible inhibitor of the chymotrypsin-like activity of the 26S proteasome in mammalian cells. The 26S proteasome is a large protein complex that degrades ubiquitinated proteins. The ubiquitin-proteasome pathway plays an essential role in regulating the intracellular concentration of specific proteins, thereby maintaining homeostasis within cells. Inhibition of the 26S proteasome prevents this targeted proteolysis, which can affect multiple signaling cascades within the cell. This disruption of normal homeostatic mechanisms can lead to cell death. Experiments have demonstrated that bortezomib is cytotoxic to a variety of cancer cell types in vitro. Bortezomib causes a delay in tumor growth in vivo in nonclinical tumor models, including multiple myeloma.

II. Position Statement

Coverage is determined through a prior authorization process with supporting clinical documentation for every request.

III. Policy

Coverage of Velcade is available when the following criteria have been met:

- Member is at least 18 years old AND
- The medication is prescribed by a hematologist/oncologist AND
- The requested use is supported by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines (NCCN Guidelines) and/or NCCN Drugs & Biologics Compendium (NCCN Compendium) with a recommendation of category level 1 or 2A.

IV. Quantity Limitations

Coverage is available to allow sufficient quantities in accordance with FDA-approved prescribing information.

V. Coverage Duration

Coverage is available for 6 months and may be renewed.
VI. Coverage Renewal Criteria

Coverage can be renewed based upon the following criteria:
- Stabilization of disease or in absence of disease progression AND
- Absence of unacceptable toxicity from the drug.

VII. Billing/Coding Information

- Velcade J9041: 1 billing unit = 0.1 mg
- Bortezomib J9044: 1 billing unit = 0.1 mg
- Available as 10 mL vials containing 3.5 mg of bortezomib as powder for reconstitution.

VIII. Summary of Policy Changes

- 5/15/19: new policy
- 1/30/20: no policy changes

IX. References


*These guidelines are not applicable to benefits covered under Medicare Advantage. Medicare Advantage benefit coverage requests are reviewed in accordance with the guidance set forth in Chapter 15 Section 50 of the Centers for Medicare & Medicaid Services Medicare Benefit Policy Manual.

The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.