UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1186-9
Program	Prior Authorization/Notification
Medication	Venclexta® (venetoclax)
P&T Approval Date	5/2016, 5/2017, 5/2018, 4/2019, 4/2020, 4/2021, 4/2022, 4/2023, 4/2024
Effective Date	7/1/2024

1. Background:

Venclexta (venetoclax) is a BCL-2 inhibitor indicated for the treatment of adult patients with chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL). Venclexta is also indicated in combination with azacitidine, or decitabine, or low-dose cytarabine for the treatment of newly diagnosed acute myeloid leukemia (AML) in adults who are age 75 years or older, or who have comorbidities that preclude use of intensive induction chemotherapy.

In addition, the National Cancer Comprehensive Network (NCCN) recommends the use of Venclexta in acute lymphoblastic leukemia (ALL); in newly diagnosed, relapsed/refractory, and blastic plasmacytoid dendritic cell neoplasm (BPDCN) AML; relapsed/refractory hairy cell leukemia; mantle cell lymphoma as second line or subsequent therapy; in relapsed or progressive multiple myeloma with t(11;14) translocation; for relapsed/refractory systemic light chain amyloidosis with t(11;14) translocation; in previously treated Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma; in accelerated/blast phase myeloproliferative neoplasm (MPN) with disease progression; and in chronic myelomonocytic leukemia (CMML).

Coverage Information:

Members will be required to meet the criteria below for coverage. For members under the age of 19 years, the prescription will automatically process without a coverage review.

Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances. Some states also mandate usage of other Compendium references. Where such mandates apply, they supersede language in the benefit document or in the notification criteria.

2. Coverage Criteria[a]:

A. Patients less than 19 years of age

1. **Venclexta** will be approved based on the following criterion:

   a. Patient is less than 19 years of age

   Authorization will be issued for 12 months.

B. Acute Lymphoblastic Leukemia (ALL)

1. **Initial Authorization**

   a. **Venclexta** will be approved based on **both** of the following criteria:

(1) Diagnosis of relapsed/refractory T-cell acute lymphoblastic leukemia (T-ALL)

-AND-

(2) Venclexta therapy to be given in combination with **one** of the following:

(a) Decitabine
(b) HyperCVAD
(c) Nelarabine
(d) Mini-hyperCVD

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Venclexta** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Venclexta therapy

Authorization will be issued for 12 months.

C. Acute Myeloid Leukemia (AML)

1. **Initial Authorization**

a. **Venclexta** will be approved based on **one** of the following criteria:

(1) **All** of the following:

(a) Diagnosis of newly-diagnosed acute myeloid leukemia (AML)

-AND-

(b) **One** of the following:

i. Used as treatment induction in candidates for intensive induction therapy

ii. Used as treatment induction in candidates for lower-intensity induction therapy

iii. Used as follow-up after induction therapy following response to previous lower intensity therapy with the same regimen

iv. Used as consolidation therapy as continuation of lower-intensity regimen used for induction

-AND-

(c) Used in combination with decitabine, azacitidine, or low-dose cytarabine

-OR-

(2) **All** of the following:

(a) Diagnosis of relapsed/refractory acute myeloid leukemia (AML)

-AND-

(b) Used as a component of repeating the initial successful induction regimen

-AND-

(c) Greater than or equal to 12 months since induction regimen if not administered continuously

-AND-

(d) Therapy was not stopped due to development of clinical resistance

-OR-

(3) **All** of the following:

(a) Diagnosis of blastic plasmacytoid dendritic cell neoplasm (BPDCN) - acute myeloid leukemia (AML)

-AND-

(b) Considered systemic disease and therapy is given as palliative intent

-AND-

(c) Patient has low performance and/or nutritional status (i.e., serum albumin <3.2 g/dL; not a candidate for intensive remission therapy or Elzonris)

-AND-

(d) Venclexta therapy to be given in combination with azacitidine, decitabine, or low-dose cytarabine

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Venclexta** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Venclexta therapy

Authorization will be issued for 12 months.

D. Chronic Lymphocytic Leukemia /Small Lymphocytic Lymphoma (CLL/SLL)

1. **Initial Authorization**

   a. **Venclexta** will be approved based on the following criterion:

      (1) Diagnosis of chronic lymphocytic leukemia (CLL)/ small lymphocytic lymphoma (SLL)

      Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Venclexta** will be approved based on the following criterion:

      (1) Patient does not show evidence of progressive disease while on Venclexta therapy

      Authorization will be issued for 12 months.

E. Chronic Myelomonocytic Leukemia (CMML)

1. **Initial Authorization**

   a. **Venclexta** will be approved based on **all** the following criteria:

      (1) Diagnosis of chronic myelomonocytic leukemia (CMML)

      -AND-

      (2) Classified as CMML-2 (less than 20% bone marrow blasts or blast equivalents)

      -AND-

      (3) Venclexta therapy to be given in combination with azacitidine or decitabine

      Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Venclexta** will be approved based on the following criterion:

      (1) Patient does not show evidence of progressive disease while on Venclexta therapy

      Authorization will be issued for 12 months.

F. Hairy Cell Leukemia

1. **Initial Authorization**

a. **Venclexta** will be approved based on **all** of the following criteria:

(1) Diagnosis of hairy cell leukemia

-AND-

(2) Disease is progressive after relapsed/refractory therapy

-AND-

(3) Disease is resistant to BRAF inhibitor therapy (i.e., Zelboraf, Tafinlar)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Venclexta** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Venclexta therapy

Authorization will be issued for 12 months.

G. Mantle Cell Lymphoma

1. **Initial Authorization**

a. **Venclexta** will be approved based on **both** of the following criteria:

(1) Diagnosis of mantle cell lymphoma (MCL)

-AND-

(2) Not used as first line therapy

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Venclexta** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Venclexta therapy

Authorization will be issued for 12 months.

H. Multiple Myeloma

1. **Initial Authorization**

   a. **Venclexta** will be approved based on **all** of the following criteria:

      (1) Diagnosis of relapsed or progressive multiple myeloma which has been previously treated

      -AND-

      (2) Patient has t(11;14) translocation

      -AND-

      (3) Venclexta therapy to be given in combination with dexamethasone

      Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Venclexta** will be approved based on the following criterion:

      (1) Patient does not show evidence of progressive disease while on Venclexta therapy

      Authorization will be issued for 12 months.

I. Myeloproliferative Neoplasms – Accelerated/Blast Phase Myeloproliferative Neoplasms

1. **Initial Authorization**

   a. **Venclexta** will be approved based on **all** of the following criteria:

      (1) Diagnosis of accelerated/blast phase myeloproliferative neoplasm

      -AND-

      (2) Used for management of disease progression of myeloproliferative neoplasm

      -AND-

      (3) Venclexta therapy to be given in combination with azacitidine or decitabine

      Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Venclexta** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Venclexta therapy

Authorization will be issued for 12 months.

J. Systemic Light Chain Amyloidosis

1. **Initial Authorization**

a. **Venclexta** will be approved based on **both** of the following criteria:

(1) Diagnosis of relapsed/refractory systemic light chain amyloidosis

-AND-

(2) Patient has t(11;14) translocation

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Venclexta** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Venclexta therapy

Authorization will be issued for 12 months.

K. Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma

1. **Initial Authorization**

a. **Venclexta** will be approved based on the following criterion:

(1) Diagnosis of Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma which has been previously treated

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Venclexta** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Venclexta therapy

Authorization will be issued for 12 months.

L. NCCN Recommended Regimens

The drug has been recognized for treatment of the cancer indication by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class
- Supply limits may be in place.

4. References:

1. Venclexta [package insert]. North Chicago, IL: AbbVie Inc. June 2022.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed February 20, 2024.

Program	Prior Authorization/Notification - Venclexta (venetoclax)
Change Control	
5/2016	New program approved by FDA on 4/11/2016. Added SLL to criteria per NCCN. Updated background and references.
5/2017	Annual review. Removed requirement for 17p deletion or TP53 mutation for CLL/SLL and added criteria for MCL per NCCN guidelines. Updated references.
5/2018	Annual review. No changes to criteria. Updated references.
4/2019	Annual review. Added coverage for AML based on prescribing information and NCCN guidelines. Updated references.
4/2020	Annual review. Updated background and criteria to align with updated labeled indication for first line use in CLL/SLL. Added general NCCN recommendations for use criteria. Updated references.
4/2021	Annual review. Updated background and criteria for multiple myeloma based on NCCN recommendations. Updated references.
4/2022	Annual review. Updated background and criteria to include acute lymphoblastic leukemia, systemic light chain amyloidosis, and Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma based on NCCN recommendations. Updated references.
4/2023	Annual review. Updated background. Specified Ph-neg disease in ALL. Added additional AML recommendations. Added state mandate and oncology medications footnote. Updated references.

4/2024	Annual review. Updated background on NCCN recommendations. Updated criteria for ALL and AML based on NCCN recommendations. Added criteria for additional indications based on NCCN recommendations for the following: hairy cell leukemia, myeloproliferative neoplasms – accelerated/blast phase myeloproliferative neoplasms, and CMML. Removed oncology medications footnote.