BORUZU® *(bortezomib) injection, for IV or subcutaneous use*
VELCADE® *(bortezomib) injection, for IV or subcutaneous use*

PA Criteria	Criteria Details
Description	Bortezomib is a reversible proteasome inhibitor.
Covered Uses (FDA approved indication)	Bortezomib is indicated for the treatment of: a. adult patients with multiple myeloma. b. adult patients with mantle cell lymphoma.
Dosing and Administration	Recommended starting dose: 1.3 mg/m^2 Administered as either IV Bolus or subcutaneous injection – recommended final concentration is based on route of administration. • **IV:** final concentration of 1 mg/mL (IV preferred for prev. untreated Mantle Cell Lymphoma) • **SC:** final concentration of 2.5 mg/mL **Multiple Myeloma:** administered for nine, six-week treatment cycles (shown below). • Retreatment may be considered for patients previously treated with Bortezomib who responded to treatment but may have relapsed at least six months after completion of treatment. • Retreatment will be started at the last tolerated dose • Bortezomib is often used in other therapy combinations for previously untreated and relapsed or refractory disease *(see Appendix)*. • **Discontinue for disease progression or unacceptable toxicity.**

Indication	Twice Weely BORTEZOMIB (Cycle one to four)												
	Week	1				2		3	4		5		6
Multiple Myeloma (Previously untreated)	Bortezomib (1.3 mg/m2)	Day 1	--	--	D4	D8	D11	Rest Period	D22	D25	D29	D32	Rest Period
	Once Weely BORTEZOMIB (Cycle five to nine)												
	Week	**1**				**2**		**3**	**4**		**5**		**6**
	Bortezomib (1.3 mg/m2)	Day 1	--	--	--	D8	--	Rest Period	D22	--	D29	--	Rest Period

Mantle Cell Lymphoma: administered as IV bolus injection (preferred) for six, three-week treatment cycles (shown below).

- IV administration of Bortezomib is preferred for previously untreated mantle cell lymphoma patients, used in combination with IV rituximab, cyclophosphamide, doxorubicin and PO prednisone.
- Bortezomib is administered first, followed by rituximab.
- Retreatment may be considered for patients previously treated with Bortezomib who responded to treatment but may have relapsed at least six months after completion of treatment.
- Retreatment will be started at the last tolerated dose.
- Bortezomib is often used in other therapy combinations for previously untreated and relapsed or refractory disease *(see Appendix)*.
- **Discontinue for disease progression or unacceptable toxicity.**

GOLD COAST HEALTH PLAN
TOTAL Care ADVANTAGE℠

Indication	Twice Weely BORTEZOMIB (six, three-week cycles)*							
	Week	1					2	3
Mantle Cell Lymphoma (Previously untreated)	**Bortezomib** (1.3 mg/m2)	Day 1	--	--	Day 4	---	D8	D11	Rest Period
	Rituximab (375 mg/m2) **Cyclophosphamide** (750 mg/m2) **Doxorubicin** (50 mg/m2)	Day 1	--	--	--	--	--	--	Rest Period
	Prednisone (100 mg/m2)	Day 1	Day 2	Day 3	Day 4	Day 5	--	--	Rest Period

Required Dose Modifications

Moderate to Severe Hepatic Impairment*: start Bortezomib at **0.7 mg/m²** per injection for first cycle.

- Consider subsequent dose escalation to 1 mg/m²
- If lower starting dose is not tolerated, consider further lowering dose to **0.5 mg/m²**

*Moderate = bilirubin > 1.5-3X ULN | Severe = bilirubin > 3X ULN

Billing and Coding Information

	11-digit NDC	11-digit NDC
BORUZU®	70121-2484-1	70121-2484-01
VELCADE	63020-049-01	63020-0049-01

HCPCS Code	Description
J9054	Injection, bortezomib, 0.1 mg - BORUZU
J9041	Injection, bortezomib, 0.1 mg – VELCADE

CPT Procedural Codes	Description
96401	Chemotherapy administration, subcutaneous or IM; non-hormonal anti-neoplastic
96409	Chemotherapy administration, IV push, single or initial substance/drug
96411	Chemotherapy administration, IV push, each additional substance/drug

*Used as an add-on code for every hour of infusion that is more than 30 min past the initial 1 hour

Product Availability

BORUZU – *Single-dose vial:* 3.5 mg/1.4 mL (2.5 mg/mL); ready-to-use formulation
VELCADE – *Single-dose vial:* 3.5 mg lyophilized powder for reconstitution

Contraindications

- Hypersensitivity to bortezomib, boron or mannitol, including anaphylactic reactions.
- Intrathecal administration.

Recommended Medical Monitoring	**Multiple Myeloma** - prior to initiating treatment: • Platelet count ≥ 70 x 109/L • ANC ≥ 1 x 109/L • Nonhematological toxicities should be resolved to Grade 1 or baseline **Mantle Cell Lymphoma** – prior to initiating treatment in combination with rituximab, cyclophosphamide, doxorubicin and prednisone: • Platelet count ≥ 100 x 109/L • ANC ≥ 1.5 x 109/L • Hemoglobin ≥ 8 g/dL (≥ 4.96 mmol/L) • Nonhematological toxicities should be resolved to Grade 1 or baseline Bortezomib has been associated with: • Peripheral neuropathy • Hypotension • Cardiac Toxicity • Pulmonary Toxicity • Posterior Reversible Encephalopathy Syndrome • GI Toxicity (N/V/D, constipation) • Thrombocytopenia and neutropenia • Tumor Lysis Syndrome • Hepatic Toxicity • Thrombotic Microangiopathy • Embryo-Fetal Toxicity Patients should be monitored for any of these reactions. Bortezomib dose may be delayed, reduced or permanently discontinued based on the severity of adverse reactions. Bortezomib can cause fetal harm when administered to a pregnant woman. Verify pregnancy status in females of reproductive potential prior to initiating Bortezomib treatment. Female patients of reproductive potential should be advised to use effective contraception during treatment with Bortezomib and for seven months after the last dose. **Drug-Drug Interactions:** Bortezomib is a major substrate for cytochrome P450 3A4. • Patients will have to be monitored for concurrent drug-drug interactions. • Concurrent use with strong 3A4 inducers is NOT recommended and should be avoided as it can decrease patient exposure to Bortezomib.

GOLD COAST HEALTH PLAN
TOTAL Care ADVANTAGE℠

<table>
<tr><td>Approval Criteria</td><td>
a. Physician administered IV push or subcutaneous injection; in-office or HOPD
i. Cannot be self-administered
b. Multiple Myeloma (must meet all):
i. Diagnosis of multiple myeloma
ii. Prescribed by or in consultation with an oncologist
iii. Patient age ≥ 18 years
iv. Platelet count ≥ 70 x 109/L
v. ANC ≥ 1 x 109/L
vi. Nonhematological toxicities Grade 1 or baseline
vii. Dose does not exceed 1.3 mg/m2
viii. Maximum six doses every 28 days
c. Mantle Cell Lymphoma (must meet all):
i. Diagnosis of mantle cell lymphoma
ii. Prescribed by or in consultation with an oncologist
iii. Patient age ≥ 18 years
iv. Platelet count ≥ 100 x 109/L
v. ANC ≥ 1.5 x 109/L
vi. Nonhematological toxicities Grade 1 or baseline
vii. Dose does not exceed 1.3 mg/m2
viii. Maximum six doses every 28 days
</td></tr>
<tr><td>Age Restriction</td><td>Adults ≥ 18 years old.</td></tr>
<tr><td>Coverage Duration</td><td>Initial: six months. Reauthorization: 12 months.

Dose will be approved according to the FDA approved labeling or within accepted standards of medical practice.</td></tr>
<tr><td>Appendix</td><td>
<table>
<tr><th>Preferred regimens for standard-risk Multiple Myeloma</th><th>Place of BORTEZOMIB therapy in Mantle Cell Lymphoma treatment</th></tr>
<tr><td>
a. DVRd – daratumumab, Bortezomib, lenalidomide, dexamethasone
b. IsaVRd – isatuximab, Bortezomib, lenalidomide, dexamethasone
c. VRd – Bortezomib, lenalidomide, dexamethasone
d. DRd – daratumumab, lenalidomide, dexamethasone
e. VCd aka CyBorD – Bortezomib, cyclophosphamide, dexamethasone
</td><td>
a. HCT ineligible due to age (≥ 65 yrs), comorbid conditions or limited fitness
i. VR-CAP – Bortezomib, rituximab, cyclophosphamide, doxorubicin, prednisone
ii. Rituximab + lenalidomide
iii. Rituximab + bendamustine
</td></tr>
</table>
</td></tr>
</table>

Preferred regimens for HIGH-RISK Multiple Myeloma	Examples of strong CYP3A4 inducers
a. **Autologous HCT Ineligible:** i. IsaVRd ii. DVRd iii. VRd or DRd (preferred for frail pts) b. **HCT Eligible** i. DVRd ii. IsaVRd	a. Carbamazepine b. Dexamethasone c. Fosphenytoin d. Phenobarbital e. Phenytoin f. Rifampin g. St. John's Wort

STATUS	DATE REVISED	REVIEW DATE	APPROVED/REVIEWED BY	EFFECTIVE DATE
Created	9/22/2025	9/22/2025	Tamara Chinarian, PharmD, Clinical Pharmacist	N/A
Approved	N/A	11/13/2025	Pharmacy & Therapeutics (P&T) Committee	11/13/2025