PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Oral – CELMoD) – Zenbexus Prior Authorization Policy
- Zenbexus™ (iberdomide capsules –Bristol Myers Squibb)

REVIEW DATE: 08/19/2026

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Zenbexus, a cereblon-modulating protein degrader (CELMoD), is indicated in combination with Darzalex Faspro® (daratumumab and hyaluronidase-fihj subcutaneous injection) and dexamethasone for the treatment of **multiple myeloma** in adults who have received at least one prior line of therapy, including a proteasome inhibitor and an immunomodulatory agent.[1]

This indication is approved under accelerated approval based on minimal residual disease-negative complete response at any time.[1] Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).

Guidelines

Zenbexus is not addressed in the National Comprehensive Cancer Network (NCCN) Multiple Myeloma guidelines yet. NCCN guidelines (version 5.2026 – January 9, 2026) recommend various regimens as primary therapy (transplant eligible and non-transplant candidates), maintenance therapy, and for previously treated multiple myeloma, including regimens containing a proteasome inhibitor or immunomodulatory agent.[2]

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Zenbexus. All approvals are provided for the duration noted below.

- **Zenbexus™ (iberdomide capsules –Bristol Myers Squibb)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. **Multiple Myeloma.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** The medication will be taken in combination with BOTH of the following (i and ii):
     - **i.** Darzalex (daratumumab intravenous infusion) or Darzalex Faspro (daratumumab and hyaluronidase-fihj subcutaneous injection); AND
     - **ii.** Dexamethasone; AND
   - **C)** Patient meets BOTH of the following (i and ii):
     - **i.** Patient has tried at least one proteasome inhibitor; AND
       Note: Examples of a proteasome inhibitor include bortezomib, Kyprolis (carfilzomib intravenous infusion), or Ninlaro (ixazomib capsules).
     - **ii.** Patient has tried at least one immunomodulatory agent.
       Note: Examples of an immunomodulatory agent include lenalidomide, pomalidomide, or Thalomid (thalidomide capsules).

CONDITIONS NOT COVERED

- **Zenbexus™ (iberdomide capsules –Bristol Myers Squibb)**

is(are) considered not medically necessary for ANY other use(s); criteria will be updated as new published data are available).

REFERENCES

1. Zenbexus™ capsules [prescribing information]. Princeton, NJ: Bristol Myers Squibb; August 2026.
2. The NCCN Multiple Myeloma Clinical Practice Guidelines in Oncology (version 5.2026 – January 9, 2026). © 2026 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on August 14, 2026.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	08/19/2026