

Clinical Policy: Romidepsin (Istodax)

Reference Number: ERX.SPA. 267

Effective Date: 12.01.18

Last Review Date: 11.18

[Revision Log](#)

See **Important Reminder** at the end of this policy for important regulatory and legal information.

Description

Romidepsin (Istodax®) is a histone deacetylase inhibitor.

FDA Approved Indication(s)

Istodax is indicated for the treatment of:

- Cutaneous T-cell lymphoma (CTCL) in patients who have received at least one prior systemic therapy;
- Peripheral T-cell lymphoma (PTCL) in patients who have received at least one prior therapy.

Limitation(s) of use: These indications are based on response rate. Clinical benefit such as improvement in overall survival has not been demonstrated.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Istodax is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Cutaneous T-Cell Lymphoma (must meet all):

1. Diagnosis of CTCL (*see Appendix D for examples of CTCL subtypes*);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Request meets one of the following (a or b):
 - a. Dose does not exceed maximum indicated in section V;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

B. Peripheral T-Cell Lymphoma (must meet all):

1. Diagnosis of peripheral T-cell lymphoma (PTCL) (*see Appendix E for examples of PTCL subtypes*);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Member has received at least one prior therapy (e.g., chemotherapy/biologic therapy, radiation therapy, hematopoietic stem cell transplantation);
5. Request meets one of the following (a or b):
 - a. Dose does not exceed maximum indicated in section V;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

C. Other diagnoses/indications

1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. All Indications in Section I (must meet all):

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions, or documentation supports that member is currently receiving Istodax for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):
 - a. New dose does not exceed maximum indicated in section V;
 - b. New dose is supported by practice guideline or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

- ### A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off-label use policy – ERX.PA.01 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALCL: anaplastic large cell lymphoma

CTCL: cutaneous T-cell lymphoma

FDA: Food and Drug Administration

MF: mycosis fungoides

PTCL: peripheral T-cell lymphoma

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): none reported

Appendix D: WHO-EORTC Classification of Cutaneous T-Cell Lymphomas* with Primary Cutaneous Manifestations

- Mycosis fungoides (MF)
 - MF variants and subtypes
 - Folliculotropic MF
 - Pagetoid reticulosis
 - Granulomatous slack skin
- Sezary syndrome (SS)
- Adult T-cell leukemia/lymphoma (ATLL)
- Primary cutaneous CD30+ lymphoproliferative disorders
 - Primary cutaneous anaplastic large cell lymphoma (ALCL)
 - Lymphomatoid papulosis
- Subcutaneous panniculitis-like T-cell lymphoma
- Extranodal NK*/T-cell lymphoma, nasal type
- *Primary cutaneous* peripheral T-cell lymphoma, unspecified (PTCL-NOS)
 - Primary cutaneous aggressive epidermotropic CD8+ T-cell lymphoma
 - Cutaneous delta/gamma T-cell lymphoma

- Primary cutaneous CD4+ small/medium-sized pleomorphic T-cell lymphoma

**CTCL is classified as a non-Hodgkin T-cell lymphoma. CTCL classification schemes are periodically advanced as new information becomes available; therefore, the above list is provided as general guidance. For additional information, see WHO's 2016 updated classification of hematological malignancies for a complete list of lymphoid neoplasms, including CTCL.⁵*

Appendix E: Peripheral T-Cell Lymphomas (PTCL) Subtypes*

- Peripheral T-cell lymphoma (PTCL), not otherwise specified (NOS)
- Angioimmunoblastic T-cell lymphoma
- Anaplastic large cell lymphoma (ALCL), ALK positive or negative
- Enteropathy-associated T-cell lymphoma
- Monomorphic epitheliotropic intestinal T-cell lymphoma

**PTCL is classified as a non-Hodgkin T-cell lymphoma. PTCL classification schemes are periodically advanced as new information becomes available; therefore, the above list is provided as general guidance. For additional information, see WHO's 2016 updated classification of hematological malignancies for a complete list of lymphoid neoplasms, including PTCL.⁵*

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CTCL/PTCL	14 mg/m ² IV over a 4-hour period on days 1, 8, and 15 of a 28-day cycle. Repeat cycles every 28 days provided that the patient continues to benefit from and tolerates the drug.	14 mg/m ²

VI. Product Availability

Kit, lyophilized powder in a 10 mg single-dose vial for injection: 11 mg romidepsin and 22 mg bulking agent povidone, USP; sterile diluent 2.4 mL of 80% propylene glycol, USP and 20% dehydrated alcohol, USP

VII. References

1. Istodax Prescribing Information. Summit, NJ: Celgene Corporation; July 2016. Available at <https://dailymed.nlm.nih.gov/dailymed/>. Accessed July 12, 2018.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed July 12, 2018.
3. Willemze R, Jaffe ES, Burg G, et al. WHO-EORTC classification for cutaneous lymphomas. *Blood*. May 2005; 105(10): 3768-85.
4. Swerdlow SH, Campo E, Pileri SA, et al. The 2016 revision of the World Health Organization classification of lymphoid neoplasms. *Blood*. 2016; 127: 2375-2390.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	07.12.18	11.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members.

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