Clinical Policy: Midostaurin (Rydapt)

Reference Number: ERX.SPA.154
Effective Date: 09.01.17
Last Review Date: 05.20
Line of Business: Commercial, Medicaid

Revision Log

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

Description
Midostaurin (Rydapt®) is a kinase inhibitor.

FDA Approved Indication(s)
Rydapt is indicated for the treatment of adult patients with:

- Newly diagnosed acute myeloid leukemia (AML) that is FLT3 mutation positive as detected by an FDA-approved test, in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation
  Limitation(s) of use: Rydapt is not indicated as a single-agent induction therapy for the treatment of patients with AML.
- Aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL)

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.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

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

I. Initial Approval Criteria

A. Acute Myeloid Leukemia (must meet all)**:**

1. Diagnosis of AML;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Positive for the FLT3 mutation;
5. If induction therapy, prescribed in combination with cytarabine and daunorubicin;
6. If consolidation therapy, prescribed in combination with cytarabine;
7. Request meets one of the following (a or b):
   a. Dose does not exceed 100 mg per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:
Commercial – Length of Benefit
Medicaid – 6 months

B. Advanced Systemic Mastocytosis (must meet all)**:**

1. Diagnosis of one of the following (a, b, or c):
   a. ASM;
   b. ASM-AHN;
   c. MCL;
2. Prescribed by or in consultation with an oncologist, allergist, or immunologist;
3. Age ≥ 18 years;

4. Request meets one of the following (a or b):
   a. Dose does not exceed 200 mg per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:
Commercial – Length of Benefit
Medicaid – 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 Rydapt 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, b, or c):
   a. AML: Dose does not exceed 100 mg per day;
   b. ASM, SM-AHN, or MCL: Dose does not exceed 200 mg per day;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

Approval duration:
Commercial – Length of Benefit
Medicaid – 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

AML: acute myeloid leukemia
ASM: aggressive systemic mastocytosis
FDA: Food and Drug Administration
MCL: mast cell leukemia
NCCN: National Comprehensive Cancer Network
SM-AHN: systemic mastocytosis with associated hematological neoplasm

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
AML induction therapy: cytarabine + daunorubicin	Cytarabine 100-200 mg/m^2 continuous IV infusion for 7 days with daunorubicin 60-90 mg/m^2 for 3 days	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
AML post-remission therapy (consolidation): cytarabine	3 g/m^2 IV over 3 hours every 12 hours on days 1, 3, and 5 for 3 to 4 cycles	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): hypersensitivity to midostaurin or any of the excipients
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
AML	50 mg PO BID with food	100 mg/day
ASM, SM-AHN, MCL	100 mg PO BID with food	200 mg/day

VI. Product Availability

Capsule: 25 mg

VII. References

1. Rydapt Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2019. Available at: www.rydapt.com. Accessed February 13, 2020.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at nccn.org. Accessed February 13, 2020.
3. National Comprehensive Cancer Network. Acute Myeloid Leukemia Version 3.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/aml.pdf. Accessed February 12, 2020.
4. National Comprehensive Cancer Network. Systemic Mastocytosis Version 2.2019. Available at: https://www.nccn.org/professionals/physician_gls/pdf/aml.pdf. Accessed February 12, 2020.
5. National Comprehensive Cancer Network. Myelodysplastic Syndromes Version 1.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/aml.pdf. Accessed February 12, 2020.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	05.17	08.17
2Q 2018 annual review: No clinically significant changes; References reviewed and updated.	03.06.18	05.18
2Q 2019 annual review: no significant changes; AML: hematologist added, FDA-approved test requirement removed; references reviewed and updated.	12.19.19	05.19
2Q 2020 annual review: no significant changes; added Medicaid line of business with 6/12 month approval durations; references reviewed and updated.	02.12.20	05.20

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.