Clinical Policy: Midostaurin (Rydapt)

Reference Number: CP.PHAR.344
Effective Date: 07/17
Last Review Date: 07/17 Revision Log
Line of Business: Medicaid

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

Description

Midostaurin (Rydapt®) is a tyrosine kinase inhibitor that inhibits multiple receptors, such as wild type FLT3, FLT3 mutant kinases internal tandem duplications and tyrosine kinase domain point mutations, and KIT (wild type and D816V mutant).

FDA approved indication

Rydapt is indicated:

- For the treatment of 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
- For the treatment of aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL)

Limitation of use: Rydapt is not indicated as a single-agent induction therapy for the treatment of patients with AML.

Policy/Criteria

Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of health plans affiliated with Centene Corporation® 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. Positive for the FLT3 mutation as detected by an FDA-approved test (e.g., LeukoStrat® CDx *FLT3* Mutation Assay);
3. Prescribed in combination with cytarabine and daunorubicin induction and cytarabine consolidation therapy;
4. Dose does not exceed 100 mg/day.

Approval duration: 6 months

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

1. Diagnosis of one of the following (a, b, or c):
   a. ASM;
   b. SM-AHN;
   c. MCL;

2. Dose does not exceed 200 mg/day.

Approval duration: 6 months

C. Other diagnoses/indications

1. Refer to CP.PHAR.57 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

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

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Documentation of positive response to therapy (e.g., sustained remission [AML], improvement in organ function [systemic mastocytosis]);
3. If request is for a dose increase, new dose does not exceed:
   a. AML: 100 mg/day for AML;
   b. ASM, SM-AHN, or MCL: 200 mg/day.

Approval duration: 12 months

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

1. Currently receiving medication via health plan benefit and documentation supports positive response to therapy.

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

2. Refer to CP.PHAR.57 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 – CP.PHAR.57 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
PO: by mouth
SM-AHN: systemic mastocytosis with associated hematological neoplasm

Appendix B: General Information

- Information on FDA-approved tests for the detection of FLT3 mutation in AML is available at: http://www.fda.gov/CompanionDiagnostics.
- In AML, the National Comprehensive Cancer Network practice guidelines recommend induction therapy with cytarabine 100-200 mg/m^2 continuous IV infusion for 7 days with idarubicin 12 mg/m^2 or daunorubicin 60-90 mg/m^2 for 3 days (category 1). For post-remission therapy, cytarabine 3 g/m^2 IV over 3 hours every 12 hours on days 1, 3, and 5 for 3 to 4 cycles (category 1), hematopoietic stem cell transplantation (category 2A), or a clinical trial (category 2A) is recommended.

V. Dosage and Administration

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

VI. Product Availability

Capsules: 25 mg

VII. References

1. Rydapt Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; April 2017. Available at: www.rydapt.com. Accessed May 10, 2017.
2. National Comprehensive Cancer Network. Acute Myeloid Leukemia Version 1.2017. Available at: https://www.nccn.org/professionals/physician_gls/pdf/aml.pdf. Accessed May 10, 2017.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created	06/17	07/17

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. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. 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. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.