Clinical Policy: Romidepsin (Istodax)
Reference Number: CP.PHAR.314
Effective Date: 01.01.17
Last Review Date: 11.20
Line of Business: Commercial, HIM, Medicaid

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 adult patients who have received at least one prior systemic therapy
- Peripheral T-cell lymphoma (PTCL) in adult patients who have received at least one prior therapy
  o This indication is approved under accelerated approval based on response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

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 Centene Corporation® that Istodax and romidepsin injection solution are 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 14 mg/m² for three days of a 28-day cycle;
         b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).
*Prescribed regimen must be FDA-approved or recommended by NCCN.

   Approval duration: 6 months

   B. Peripheral T-Cell Lymphoma (must meet all):
      1. Diagnosis of 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) *(see Appendix B for examples)*;

*Prior authorization may be required for prior therapies*

5. Request meets one of the following (a or b):
   a. Dose does not exceed 14 mg/m² for three days of a 28-day cycle;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

*Prescribed regimen must be FDA-approved or recommended by NCCN.*

**Approval duration: 6 months**

**C. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

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

1. Currently receiving medication via Centene benefit, 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, meets one of the following (a or b):
   a. New dose does not exceed 14 mg/m² for three days of a 28-day cycle;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

*Prescribed regimen must be FDA-approved or recommended by NCCN.*

**Approval duration: 12 months**

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

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

*Approval duration: Duration of request or 6 months (whichever is less)*; or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

**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 policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*
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 for all relevant lines of business and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/ Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTCL - examples of first-line and subsequent therapy:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Brentuximab vedotin + CHP (cyclophosphamide, doxorubicin, and prednisone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- DHAP (dexamethasone, cisplatin, cytarabine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- ESHAP (etoposide, methylprednisolone, cytarabine, cisplatin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Belinostat, brentuximab vedotin, romidepsin as single agents</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
None reported

Appendix D: WHO-EORTC Classification of CTCL* with Primary Cutaneous Manifestations
- Mycosis fungoides (MF)
  - MF variants and subtypes
    - Folliculotropic MF
    - Pagetoid reticulosis
    - Granulomatous slack skin
- Sezary syndrome
- Adult T-cell leukemia/lymphoma
- Primary cutaneous CD30+ lymphoproliferative disorders
  - Primary cutaneous anaplastic large cell lymphoma
  - Lymphomatoid papulosis
- Subcutaneous panniculitis-like T-cell lymphoma
- Extranaodal NK*/T-cell lymphoma, nasal type
- **Primary cutaneous** peripheral T-cell lymphoma, unspecified
  - Primary cutaneous aggressive epidermotropic CD8+ T-cell lymphoma
CLINICAL POLICY
Romidepsin

- 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.

Appendix E: PTCL Subtypes/Histologies*
- PTCL, not otherwise specified
- Anaplastic large cell lymphoma
- Angioimmunoblastic T-cell lymphoma
- Enteropathy-associated T-cell lymphoma
- Monomorphic epitheliotropic intestinal T-cell lymphoma
- Nodal peripheral T-cell lymphoma with TFH phenotype
- Follicular T-cell lymphoma

*PTLC 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.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTCL/PTCL</td>
<td>14 mg/m² 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.</td>
<td>14 mg/m²/dose</td>
</tr>
</tbody>
</table>

VI. Product Availability

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Romidepsin (Istodax)</td>
<td>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</td>
</tr>
<tr>
<td>Romidepsin</td>
<td>Injection solution in a single-dose vial: 10 mg/2 mL, 27.5 mg/5.5 mL</td>
</tr>
</tbody>
</table>

VII. References

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9315</td>
<td>Injection, romidepsin, 1 mg</td>
</tr>
</tbody>
</table>

Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy split from CP.PHAR.182.Excellus Oncology.</td>
<td>01.17</td>
<td>02.17</td>
</tr>
<tr>
<td>Policy converted to new template. Annual Review. Safety criteria was applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs. Authorization limits extended from 3 and 6 months to 6 and 12 months for initial and continued approval, respectively. Removed Stage I-IIA from Cutaneous T-Cell Lymphoma NCCN criteria due to NCCN 2B rating for stage I-IIA with blood involvement.</td>
<td>08.17</td>
<td>11.17</td>
</tr>
<tr>
<td>4Q 2018 annual review: HIM-Medical Benefit added; summarized NCCN and FDA-approved uses for improved clarity; added age requirement and specialist involvement in care; PTCL: extended initial approval duration from 3 to 6 months; updated continued therapy section to include language for continuity of care; references reviewed and updated.</td>
<td>07.12.18</td>
<td>11.18</td>
</tr>
<tr>
<td>No significant changes; modified HIM-Medical Benefit to HIM line of business.</td>
<td>02.25.19</td>
<td></td>
</tr>
<tr>
<td>4Q 2019 annual review: FDA dosing cycle details added; FDA/NCCN labeling requirement added; references reviewed and updated.</td>
<td>08.20.19</td>
<td>11.19</td>
</tr>
<tr>
<td>RT4: Added new dose form romidepsin injection solution to the policy.</td>
<td>03.30.20</td>
<td></td>
</tr>
</tbody>
</table>
Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.18.20</td>
<td>11.20</td>
</tr>
</tbody>
</table>

4Q 2020 annual review: added Commerical line of business to policy; updated Appendix B; updated Appendix E with additional PTCL subtypes per NCCN; references reviewed and updated.

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.

©2017 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene® and Centene Corporation® are registered trademarks exclusively owned by Centene Corporation.