Clinical Policy: Glasdegib (Daurismo)
Reference Number: CP.PHAR.413
Effective Date: 01.08.19
Last Review Date: 02.20
Line of Business: Commercial, HIM, Medicaid

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

Description
Glasdegib (Daurismo™) is a Hedgehog (Hh) pathway inhibitor.

FDA Approved Indication(s)
Daurismo is indicated, in combination with low-dose cytarabine, for the treatment of newly-diagnosed acute myeloid leukemia (AML) in adult patients who are \( \geq 75 \) years old or who have comorbidities that preclude use of intensive induction chemotherapy.

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 Daurismo 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 \( \geq 18 \) years;
      4. Member meets one of the following (a or b):
         a. Age \( \geq 75 \) years;
         b. Medical justification supports inability to use intensive induction chemotherapy (see Appendix D for examples);
         c. Member responded to then relapsed after Daurismo induction therapy \( \geq 12 \) months ago;
      5. Prescribed in combination with low-dose cytarabine;
      6. Request meets one of the following (a or b):
         a. Dose does not exceed 100 mg (1 tablet) per day;
         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:
Medicaid/HIM – 6 months
Commercial – Length of Benefit
B. 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. Acute Myeloid Leukemia (must meet all):
   1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Daurismo for a covered indication and has received this medication for at least 30 days;
   2. Member is responding positively to therapy;
   3. Prescribed in combination with low-dose cytarabine;
   4. If request is for a dose increase, request meets one of the following (a or b):
      a. New dose does not exceed 100 mg (1 tablet) per day;
      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:
   Medicaid/HIM – 12 months
   Commercial – Length of Benefit

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
   AML: acute myeloid leukemia
   FDA: Food and Drug Administration
   Hh: Hedgehog

   Appendix B: Therapeutic Alternatives
   Not applicable
Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): Daurismo is embryotoxic, fetotoxic, and teratogenic in animals. Since Daurismo can cause embryo-fetal death or severe birth defects when administered to a pregnant woman, conduct pregnancy testing in females of productive potential prior to initiation of Daurismo. Advise males and females to use effective contraception.

Appendix D: General Information

- The management of AML is divided into induction and postremission (consolidation) therapy. Induction usually includes intensive chemotherapy (e.g., standard [100-200 mg/m²] or high [2 g/m²] dose cytarabine, fludarabine), but many adults with AML are unable to undergo intensive chemotherapy due to its toxicities. Some examples of reasons why members may not qualify for intensive induction chemotherapy include, but are not limited to:
  - Baseline Eastern Cooperative Oncology Group (ECOG) performance status ≥ 2
  - Severe cardiac comorbidity (e.g., history of congestive heart failure requiring treatment, ejection fraction ≤ 50%, or chronic stable angina)
  - Baseline creatinine > 1.3 mg/dL
  - Member is age ≥ 60 years and declines intensive chemotherapy

V. Dosage and Administration

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<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
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<tr>
<td>AML</td>
<td>100 mg PO QD on days 1 to 28 in combination with cytarabine 20 mg SC BID on days 1 to 10 of each 28-day cycle</td>
<td>100 mg/day</td>
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VI. Product Availability

  Tablets: 25 mg, 100 mg

VII. References


Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>Policy created</td>
<td>01.08.19</td>
<td>02.19</td>
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<tr>
<td>No significant changes; finalized line of business to apply to HIM.</td>
<td>04.22.19</td>
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<tr>
<td>1Q 2020 annual review: removed HIM disclaimer for HIM NF drugs; AML NCCN recommended use added for relapsed disease; references reviewed and updated.</td>
<td>11.19.19</td>
<td>02.20</td>
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**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.

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<tr>
<td>RT4: Removed limitations of use from FDA approved indications section per labeling update</td>
<td>03.24.20</td>
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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.

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