

## **Clinical Policy: Ivosidenib (Tibsovo)**

Reference Number: CP.PHAR.137

Effective Date: 08.21.18

Last Review Date: 11.18

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Ivosidenib (Tibsovo<sup>®</sup>) is an isocitrate dehydrogenase-1 (IDH-1) inhibitor.

### **FDA Approved Indication(s)**

Tibsovo is indicated for the treatment of adult patients with relapsed or refractory acute myeloid leukemia (AML) with a susceptible IDH1 mutation as detected by an FDA-approved test.

### **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<sup>®</sup> that Tibsovo 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. Disease has relapsed or is refractory following treatment with first-line agents (e.g., cytarabine, idarubicin, daunorubicin, cladribine, midostaurin);
  - b. Age  $\geq$  60 years;
5. Presence of an IDH1 mutation as detected by an FDA-approved test (e.g., Abbott RealTime<sup>™</sup> IDH1 assay);
6. Dose does not exceed one of the following (a or b):
  - a. New dose does not exceed 500 mg (2 tablets) 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*).

##### **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 Tibsovo 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 500 mg (2 tablets) 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*).

#### **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

IDH1: isocitrate dehydrogenase-1

### *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.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
cytarabine plus idarubicin or daunorubicin	For age < 60 years: e.g. cytarabine 100 – 200 mg/m <sup>2</sup> continuous IV infusion x 7 days with idarubicin 12 mg/m <sup>2</sup> IV or daunorubicin 60-90 mg/m <sup>2</sup> IV x 3 days	varies
cytarabine plus daunorubicin and midostaurin	For age < 60 years: e.g. cytarabine 200 mg/m <sup>2</sup> continuous IV infusion x 7 days with daunorubicin 60 mg/m <sup>2</sup> IV x 3 days and midostaurin 50 mg PO q12h, days 8-12	varies
cytarabine plus daunorubicin and cladribine	For age < 60 years: e.g. cytarabine 200 mg/m <sup>2</sup> continuous IV infusion x 7 days with daunorubicin 60 mg/m <sup>2</sup> IV x 3 days and cladribine 5 mg/m <sup>2</sup> IV x 5 days	varies

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

*Appendix C: Contraindications/Boxed Warnings*

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

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
AML	500 mg PO QD until disease progression or unacceptable toxicity	500 mg/day

**VI. Product Availability**

Tablet: 250 mg

**VII. References**

1. Tibsovo Prescribing Information. Cambridge, MA: Agios Pharmaceuticals, Inc.; July 2018. Available at: [www.tibsovo.com](http://www.tibsovo.com). Accessed August 9, 2018.
2. Ivosidenib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: [http://www.nccn.org/professionals/drug\\_compendium](http://www.nccn.org/professionals/drug_compendium). Accessed August 8, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	08.21.18	11.18
No significant changes; added HIM line of business per SDC.	02.01.19	

**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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**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.

**For Health Insurance Marketplace members**, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the non-formulary policy; HIM.PA.103.

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