

Clinical Policy: Glasdegib (Daurismo)

Reference Number: CP.PHAR.413

Effective Date: 01.08.19

Last Review Date: 02.19

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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 ≥ 75 years old or who have comorbidities that preclude use of intensive induction chemotherapy.

Limitation(s) of use: Daurismo has not been studied in patients with the comorbidities of severe renal impairment or moderate-to-severe hepatic impairment.

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 ≥ 18 years;
4. Member meets one of the following (a or b):
 - a. Age ≥ 75 years;
 - b. Medical justification supports inability to use intensive induction chemotherapy (*see Appendix D for examples*);
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*).

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*).

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 $\leq 50\%$, or chronic stable angina)
 - Baseline creatinine > 1.3 mg/dL
 - Member is age ≥ 60 years and declines intensive chemotherapy

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
AML	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	100 mg/day

VI. Product Availability

Tablets: 25 mg, 100 mg

VII. References

1. Daurismo Prescribing Information. New York, NY: Pfizer, Inc.; November 2018. Available at: <http://labeling.pfizer.com/ShowLabeling.aspx?id=11336>. Accessed December 14, 2018.
2. National Comprehensive Cancer Network. Acute Myeloid Leukemia Version 3.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed December 14, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01.08.19	02.19
No significant changes; finalized line of business to apply to HIM.	04.22.19	

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.

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.

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.

©2019 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.