Clinical Policy: Ivosidenib (Tibsovo)

Reference Number: PA.CP.PHAR.137
Effective Date: 10.17.18
Last Review Date: 10.17.18

Revision Log

Description
Ivosidenib (Tibsovo®) 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 PA Health & Wellness® 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. 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 ≥ 60 years;
4. Presence of an IDH1 mutation as detected by an FDA-approved test (e.g., Abbott RealTime™ IDH1 assay);
5. 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: 6 months

B. Other diagnoses/indications

1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53.

II. Continued Therapy

A. Acute Myeloid Leukemia (must meet all)**:**

1. Currently receiving medication via Pennsylvania Health and Wellness benefit or member has previously met all initial approval criteria or the Continuity of Care Policy (PA.LTSS.PHAR.01) applies;
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: 12 months

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

1. Currently receiving medication via Pennsylvania Health and Wellness benefit or member has previously met all initial approval criteria or the Continuity of Care Policy (PA.LTSS.PHAR.01) applies.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53.

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 – PA.CP.PMN.53 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^2 continuous IV infusion x 7 days with idarubicin 12 mg/m^2 IV or daunorubicin 60-90 mg/m^2 IV x 3 days	varies
cytarabine plus daunorubicin and midostaurin	For age < 60 years: e.g. cytarabine 200 mg/m^2 continuous IV infusion x 7 days with daunorubicin 60 mg/m^2 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^2 continuous IV infusion x 7 days with daunorubicin 60 mg/m^2 IV x 3 days and cladribine 5 mg/m^2 IV x 5 days	varies

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

- 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. Accessed August 9, 2018.
2. Ivosidenib. In:National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed August 8, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
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