

## Clinical Policy: Romidepsin (Istodax)

Reference Number: LA.PHAR.314

Effective Date: 11.04.23

Last Review Date: 04.04.24 ~~06.16.23~~

Line of Business: Medicaid

[Coding Implications](#)

[Revision Log](#)

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

**\*\*Please note: This policy is for medical benefit\*\***

### Description

Romidepsin (Istodax<sup>®</sup>) 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.

### 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 Louisiana Healthcare Connections that Istodax and romidepsin injection solution are **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. T-Cell Lymphoma (must meet all):

1. Diagnosis of one of the following T-cell lymphomas (a, b, c, d, or e):
  - a. CTCL (*see Appendix D for examples of subtypes*);
  - b. Hepatosplenic T-cell lymphoma;
  - c. Extranodal NK/T-cell lymphoma;
  - d. Peripheral T-cell lymphoma (*see Appendix E for examples of subtypes*);
  - e. Breast implant-associated anaplastic large cell lymphoma;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age  $\geq$  18 years;
4. Failure of at least one prior systemic therapy, unless member has mycosis fungoides or Sezary syndrome;
5. For Istodax requests, member must use romidepsin, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Request meets one of the following (a or b):
  - a. Dose does not exceed 14 mg/m<sup>2</sup> on days 1, 8, and 15 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**

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: LA.PMN.53 for Medicaid.

## **II. Continued Therapy**

#### **A. T-Cell Lymphoma** (must meet all):

1. Currently receiving medication via Louisiana Healthcare Connections 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. For Istodax requests, member must use romidepsin, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, meets one of the following (a or b):
  - a. New dose does not exceed 14 mg/m<sup>2</sup> on days 1, 8, and 15 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. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: LA.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 policy – LA.PMN.53 for Medicaid or evidence of coverage documents.

## **IV. Appendices/General Information**

#### *Appendix A: Abbreviation/Acronym Key*

CTCL: cutaneous T-cell lymphoma  
FDA: Food and Drug Administration  
MF: mycosis fungoides

NCCN: National Comprehensive Cancer  
Center

#### *Appendix B: Therapeutic Alternatives*

Not applicable

*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
  - Cutaneous anaplastic large cell lymphoma
  - Lymphomatoid papulosis
- Subcutaneous panniculitis-like T-cell lymphoma
- Primary cutaneous peripheral T-cell lymphoma, not otherwise unspecified
- Primary cutaneous peripheral T-cell lymphoma, rare subtypes
  - Primary cutaneous delta/gamma T-cell lymphoma
  - CD8+ AECTCL (primary cutaneous aggressive epidermotropic CD8+ cytotoxic T-cell lymphoma)
  - Primary cutaneous CD4+ small/medium T-cell lymphoproliferative disorder
  - Primary cutaneous acral CD8+ T-cell lymphoma
- MF is the most common cutaneous T-cell lymphoma. Sezary syndrome is closely related to MF accounting for less than 5% of cutaneous lymphomas.

*\*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: Types of Peripheral T-Cell Lymphomas\**

- Peripheral T-cell lymphoma, not otherwise specified
- Enteropathy-associated T-cell lymphoma (EATL)
- Monomorphic epitheliotropic intestinal T-cell lymphoma (MEITL)
- Angioimmunoblastic T-cell lymphoma (AITL), including nodal peripheral T-cell lymphoma with TFH phenotype (PTCL, TFH), and follicular T-cell lymphoma (FTCL)
- Anaplastic large cell lymphoma

*\*Although the FDA-labeled indication for peripheral T-cell lymphoma was withdrawn in August 2021 following findings from the confirmatory phase 3 trial, the NCCN continues to support use in this indication based on the results of the phase 2 trial and other subsequent trials.*

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
CTCL	14 mg/m <sup>2</sup> IV over a 4-hour period on days 1, 8, and 15 of a 28-day cycle. Repeat cycles every 28 days	14 mg/m <sup>2</sup> /dose

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Indication	Dosing Regimen	Maximum Dose
	provided that the patient continues to benefit from and tolerates the drug.	

#### VI. Product Availability

Single-dose vial: 10 mg

#### VII. References

1. Istodax Prescribing Information. Summit, NJ: Celgene Corporation; July 2021. Available at: [https://packageinserts.bms.com/pi/pi\\_istodax.pdf](https://packageinserts.bms.com/pi/pi_istodax.pdf). Accessed ~~July 28, 2022~~ August 6, 2023.
2. 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 ~~July 28, 2022~~ August 6, 2023.
3. National Comprehensive Cancer Network. Primary Cutaneous Lymphomas Version ~~2-2022~~ 1.2023. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/primary\\_cutaneous.pdf](https://www.nccn.org/professionals/physician_gls/pdf/primary_cutaneous.pdf). Accessed ~~July 28, 2022~~ August 6, 2023.
4. National Comprehensive Cancer Network. T-Cell Lymphomas Version ~~2-2022~~ 1.2023. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/t-cell.pdf](https://www.nccn.org/professionals/physician_gls/pdf/t-cell.pdf). Accessed ~~July 28, 2022~~ August 6, 2023.
5. Willemze R, Cerroni L, Kempf W, et al. The 2018 update of the WHO-EORTC classification for primary cutaneous lymphomas. *Blood*. May 2019; 133: 1703-1714.
6. Swerdlow SH, Campo E, Pileri SA, et al. The 2016 revision of the World Health Organization classification of lymphoid neoplasms. *Blood*. 2016; 127: 2375-2390.

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#### 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.

HCPSC Codes	Description
J9319	Injection, romidepsin, <u>0.1 mg</u>
<u>J9318</u>	<u>Injection, romidepsin, non-lyophilized, 0.1 mg</u>

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted corporate to local policy.	06.16.23	<u>10.05.23</u>
<u>Annual review: : no significant changes; updated J code and added "J9318" code; references reviewed and updated.</u>	<u>04.04.24</u>	

#### 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

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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. LHCC 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.

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