Midostaurin

Included Products: Rydapt (midostaurin)

Nonformulary for outpatient benefit. PA required on medical benefit.

Created: 07/13/2017 *Revised:* 07/13/2017 *Reviewed:* 07/13/2017 *Updated:* 09/20/2021

All Diagnoses

Initial Criteria		If yes	If no
1.	Is the treatment being prescribed or supervised by a hematologist or oncologist, as appropriate, for the type of cancer?	Continue to #2.	Continue to #5.
2.	Is the treatment supported for the diagnosis in the NCCN guidelines?	Continue to #4.	Continue to #3.
3.	Is the treatment being used according to the FDA indication?	Continue to #4.	Request external specialty review.
4.	Does the request meet criteria for treatment coverage specified in Guideline Note 12 of the Prioritized List of Health Services, considering treatment of cancer with little or no benefit?	Continue to #10.	Do not approve.
5.	Is the treatment being prescribed by a hematologist, oncologist, or immunologist?	Continue to #6.	Do not approve.
6.	Does the member have a diagnosis of aggressive systemic mastocytosis (ASM)?	Continue to #7.	Continue to #9.
7.	Is the aggressive systemic mastocytosis without the D816V c-Kit mutation as determined with an FDA-approved test or with c-Kit mutational status unknown?	Continue to #8.	Continue to #10.
8.	Has the member failed imatinib?	Continue to #10.	Do not approve.
9.	Does the member have systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL)?	Continue to #10.	Do not approve.
10.	Approve for 12 months.		

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Renewal Criteria: Cancer		If yes	If no
1.	Is there evidence of tumor response and resolution or improvement of disease-related signs and symptoms?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		
Renewal Criteria: Systemic Mastocytosis		**If yes**	**If no**
1.	Is there documentation of a positive hematological response?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		