Market Applicability							
Market	**DC**	**GA**	**KY**	**MD**	**NJ**	**NY**	**WA**
Applicable	X	X	X	X	X	X	X

Istodax (romidepsin)

Override	Approval Duration
Prior Authorization	1 year

Medication
Istodax (romidepsin)

APPROVAL CRITERIA

Requests for Istodax (romidepsin) may be approved for if the following criteria are met:

I. Individuals has a diagnosis of T-cell lymphoma or leukemia; **AND**
II. Individual is using for relapsed or refractory disease following at least one prior systemic therapy;

OR
III. Individual has a diagnosis of Mycosis Fungoides or Sézary Syndrome (NCCN 2A).

Requests for Istodax (romidepsin) may not be approved when the above criteria are not met and for all other indications.

State Specific Mandates		
State name N/A	Date effective N/A	Mandate details (including specific bill if applicable) N/A

Key References:

1. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2019. URL: http://www.clinicalpharmacology.com. Updated periodically.
2. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed: April 1, 2019.
3. DrugPoints® System [electronic version]. Truven Health Analytics, Greenwood Village, CO. Updated periodically.
4. Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2019; Updated periodically.
5. NCCN Clinical Practice Guidelines in Oncology™. © 2019 National Comprehensive Cancer Network, Inc. For additional information visit the NCCN website: http://www.nccn.org/index.asp. Accessed on April 1, 2019.
    a. Primary Cutaneous Lymphomas. V2.2019. Revised December 17, 2018.
    b. T-Cell Lymphomas. V2.2019. Revised December 17, 2018.

This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.
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