

- POLICY:** Oncology – Romidepsin Products (Istodax)
- Istodax® (romidepsin injection for intravenous use – Celgene)
 - Romidepsin injection for intravenous use – authorized generics – various

DATE REVIEWED: 06/03/2020

OVERVIEW

Romidepsin (Istodax, authorized generics) is a histone deacetylase (HDAC) inhibitor which catalyzes the removal of acetyl groups from acetylated lysine residues in histones resulting in gene expression modulation.¹ Romidepsin also catalyzes the removal of acetyl groups from non-histone proteins. *In vitro*, romidepsin induces cell cycle arrest and death due to the accumulation of acetylated histones.

Romidepsin is indicated for the treatment of cutaneous T-cell lymphoma (CTCL) in patients who have received at least one prior systemic therapy and for the treatment of peripheral T-cell lymphoma (PTCL) in patients who have received at least one prior therapy.¹

Guidelines

The National Comprehensive Cancer Network (NCCN) Primary Cutaneous Lymphomas practice guidelines (version 2.2020 – April 10, 2020) recommend romidepsin as systemic therapy for mycosis fungoides/Sezary syndrome with or without skin-directed therapy and as a single agent for relapsed or refractory primary cutaneous CD30+ T-cell lymphoproliferative disorders.^{2,3}

The NCCN T-Cell Lymphomas practice guidelines (version 1.2020 – January 6, 2020) recommend romidepsin as a single agent for the second-line or subsequent therapy of relapsed or refractory peripheral T-cell lymphomas including anaplastic large cell lymphoma; peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, and nodal peripheral T-cell lymphoma with T-follicular helper (TFH) phenotype; follicular T-cell lymphoma; extranodal NK/T-cell lymphoma – nasal type; and hepatosplenic gamma-delta T-cell lymphoma.^{3,4}

POLICY STATEMENT

Prior authorization is recommended for medical benefit coverage of romidepsin. Approval is recommended for those who meet the Criteria and Dosing for the listed indication(s). Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below.

Because of the specialized skills required for evaluation and diagnosis of patients treated with romidepsin as well as the monitoring required for adverse events and long-term efficacy, approval requires romidepsin to be prescribed by or in consultation with a physician who specializes in the condition being treated.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of romidepsin is recommended in those who meet the following criteria:

FDA-Approved Indications

- 1. T-Cell Lymphoma, Peripheral.** Approve for 1 year if the patient meets the following (A, B, and C):
- A) The patient has relapsed or refractory disease; AND
 - B) Romidepsin is used as a single agent; AND
 - C) Romidepsin is prescribed by or in consultation with an oncologist.

Dosing. Approve the following dosing regimen (A and B):

- A) Each individual dose must not exceed 14 mg/m² administered intravenously; AND
- B) The dose is administered on Days 1, 8, and 15 of each 28-day cycle.¹

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- 2. Cutaneous T-Cell Lymphoma – Mycosis Fungoides/Sezary Syndrome.** Approve for 1 year if the patient meets the following (A and B)
- A) The patient has received at least one prior systemic therapy; AND
 - B) Romidepsin is prescribed by or in consultation with an oncologist or dermatologist.

Dosing. Approve the following dosing regimen (A and B):

- A) Each individual dose must not exceed 14 mg/m² administered intravenously; AND
- B) The dose is administered on Days 1, 8, and 15 of each 28-day cycle.¹

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- 3. Cutaneous T-Cell Lymphoma – Cutaneous CD30+ T-Cell Lymphoproliferative Disorders.** Approve for 1 year if the patient meets the following (A, B, C, and D):
- A) The patient has relapsed or refractory disease; AND
 - B) The patient has one of the following diagnoses (i or ii):
 - i. Primary cutaneous anaplastic large cell lymphoma with multifocal lesions; OR
 - ii. Cutaneous anaplastic large cell lymphoma with regional nodes; AND
 - C) Romidepsin is used as a single agent; AND
 - D) Romidepsin is prescribed by or in consultation with an oncologist.

Dosing. Approve the following dosing regimen (A and B):

- A) Each individual dose must not exceed 14 mg/m² administered intravenously; AND
- B) The dose is administered on Days 1, 8, and 15 of each 28-day cycle.¹

Other Uses with Supportive Evidence

- 4. Extranodal NK/T-Cell Lymphoma, Nasal Type.** Approve for 1 year if the patient meets the following (A, B, and C):
- A) The patient has relapsed/refractory disease following combination, asparaginase-based chemotherapy; AND
 - B) Romidepsin is used as a single agent; AND
 - C) Romidepsin is prescribed by or in consultation with an oncologist.

Dosing. Approve the following dosing regimen (A and B):

- A) Each individual dose must not exceed 14 mg/m² administered intravenously; AND
- B) The dose is administered on Days 1, 8, and 15 of each 28-day cycle.¹

5. Hepatosplenic Gamma-Delta T-Cell Lymphoma. Approve for 1 year if the patient meets the following (A, B, and C):

- A) Romidepsin is used as subsequent therapy after two primary treatment regimens; AND
- B) Romidepsin is used as a single agent; AND
- C) Romidepsin is prescribed by or in consultation with an oncologist.

Dosing. Approve the following dosing regimen (A and B):

- A) Each individual dose must not exceed 14 mg/m² administered intravenously; AND
- B) The dose is administered on Days 1, 8, and 15 of each 28-day cycle.¹

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Romidepsin has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions.

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Istodax® injection for intravenous use. [prescribing information]. Summit, NJ: Celgene Corporation; November 2018.
2. The NCCN Primary Cutaneous Lymphomas Clinical Practice Guidelines in Oncology (Version 2.2020 – April 10, 2020). © 2020 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed May 27, 2020.
3. The NCCN Drugs and Biologics Compendium. © 2020 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed on May 27, 2020. Search term: romidepsin.
4. The NCCN T-Cell Lymphomas Clinical Practice Guidelines in Oncology (Version 1.2020 – January 6, 2020). © 2020 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed May 27, 2020.

HISTORY

Type of Revision	Summary of Changes	Date Reviewed
New Policy	--	06/05/2019
update 06/26/2019	Added authorized generics to policy. Changed Istodax to romidepsin in policy. Changed policy name to Oncology – Romidepsin Products (Istodax).	Not applicable
Annual Revision	No change to criteria.	06/03/2020