

Revuforj (revumenib)

Disclaimer

Clinical guidelines are developed and adopted to establish evidence-based clinical criteria for utilization management decisions. Clinical guidelines are applicable according to policy and plan type. The Plan may delegate utilization management decisions of certain services to third parties who may develop and adopt their own clinical criteria.

Coverage of services is subject to the terms, conditions, and limitations of a member's policy, as well as applicable state and federal law. Clinical guidelines are also subject to in-force criteria such as the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) for Medicare Advantage plans. Please refer to the member's policy documents (e.g., Certificate/Evidence of Coverage, Schedule of Benefits, Plan Formulary) or contact the Plan to confirm coverage.

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Summary

Leukemia is a cancer of the blood and bone marrow. The body produces abnormal white blood cells. Acute leukemia has rapid progression unlike chronic leukemia which can progress over years. The most common type of acute leukemia in adults is acute myeloid leukemia (AML) where the myeloid cells turn cancerous. The most common type of acute leukemia in pediatrics is acute lymphoblastic leukemia (ALL) where the lymphoid cells (usually B- or T-cells) turn cancerous.. Mixed phenotype acute leukemia is a hybrid that shows features of both AML and ALL.

Relapsed or refractory acute leukemia is when the cancer returns after a period of remission (relapsed) or fails to respond to initial treatment (refractory).

KMT2A translocation occurs in ~10% of childhood and adult ALL. KMT2A translocation is most prevalent in infants and children. NPM1 mutation occurs in ~30% of adult AML cases and is rare in childhood AML.

Definitions

“Documentation” refers to written information, including but not limited to:

- Up-to-date chart notes, relevant test results, and/or relevant imaging reports to support diagnoses; or
- Prescription claims records, and/or prescription receipts to support prior trials of formulary alternatives.

“No evidence of” indicates that the reviewer has not identified any records of the specified item or condition within the submitted materials or claims history. In the absence of such evidence, the member is considered eligible. If any evidence of the item or condition is present upon review of the request, the member does not qualify.

“[s]” indicates state mandates may apply.

Clinical Indications

Medical Necessity Criteria for Clinical Review

General Medical Necessity Criteria

The Plan considers Revuforj (revumenib) medically necessary when ALL of the following criteria are met:

1. The medication is prescribed by or in consultation with an oncologist or hematologist; *AND*

2. The member is 1 year of age or older; *AND*
3. The member meets ALL of the following:
 - a. No evidence of QTcF >450 msec; *and*
 - b. No evidence of estimated glomerular filtration rate <60 mL/min/1.73 m²; *and*
 - c. No evidence of total bilirubin >1.5 x the upper limit of normal (ULN); *and*
 - d. No evidence of aminotransferases >3 x ULN; *and*
 - e. No evidence of left ventricular ejection fraction <50%; *and*
 - f. No evidence of ONE of the following:
 - i. Eastern Cooperative Oncology Group performance status score >2 if 18 years of age and older; *or*
 - ii. Karnofsky Performance Scale score <50 if 16 to less than 18 years of age; *or*
 - iii. Lansky Performance score <50 if less than 16 years of age; *AND*
4. Revuforj (revumenib) is being prescribed at a dose and frequency that is within FDA approved labeling (see [Appendix A](#)) OR is supported by compendia or evidence-based published dosing guidelines for the requested indication; *AND*
5. The member meets the applicable [Medical Necessity Criteria for Initial Clinical Review](#) or [Subsequent Clinical Review](#) listed below.

[Medical Necessity Criteria for Initial Clinical Review](#)

Initial Indication-Specific Criteria

Relapsed or Refractory Acute Leukemia with a Lysine Methyltransferase 2A Gene (KMT2A) Translocation

The Plan considers Revuforj (revumenib) medically necessary when ALL of the following criteria are met:

6. The member meets the above [General Medical Necessity Criteria](#); *AND*
7. The member has a diagnosis of acute leukemia and has reappearance of blasts in the bone marrow and/or peripheral blood; *AND*
8. The member meets ONE of the following types of acute leukemia:
 - a. Acute myeloid leukemia (AML); *or*
 - b. Acute lymphoblastic leukemia (ALL); *or*
 - c. Mixed phenotype acute leukemia (MPAL); *AND*
9. The disease is relapsed or refractory; *AND*
10. The disease is positive for lysine methyltransferase 2A gene (KMT2A) translocation.

If the above prior authorization criteria are met, the requested product will be authorized for up to 12-months.^[a]

Relapsed or Refractory Acute Myeloid Leukemia (AML) with a Susceptible Nucleophosmin 1 (NPM1) Mutation

The Plan considers Revuforj (revumenib) medically necessary when ALL of the following criteria are met:

6. The member meets the above [General Medical Necessity Criteria](#); *AND*
7. The member has a diagnosis of acute leukemia and has reappearance of blasts in the bone marrow and/or peripheral blood; *AND*
8. The member has acute myeloid leukemia (AML); *AND*
9. The disease is relapsed or refractory; *AND*
10. The disease has a susceptible nucleophosmin 1 (NPM1) mutation; *AND*
11. The member has no satisfactory alternative treatment options (e.g., chemotherapy, targeted therapies if co-mutations exist); *AND*
12. IF the member is 18 years of age or older, there is a documented contraindication to or history of intolerance to Komzifti (ziftomenib) without disease progression^[s].

If the above prior authorization criteria are met, the requested product will be authorized for up to 12-months.^[s]

Continued Care

[Medical Necessity Criteria for Subsequent Clinical Review](#)

Subsequent Indication-Specific Criteria

Relapsed or Refractory Acute Leukemia with a KMT2A Translocation or Susceptible NPM1 Mutation

The Plan considers Revuforj (revumenib) medically necessary when ALL of the following criteria are met:

1. The member meets the above applicable [General Medical Necessity Criteria](#); *AND*
2. The member has experienced a documented improvement in disease (e.g., signs or symptoms); *AND*
3. There is no evidence indicating disease progression; *AND*
4. There is no evidence of unacceptable toxicity or adverse reactions to Revuforj (revumenib).

If the above reauthorization criteria are met, the requested product will be authorized for up to 12-months.^[s]

[Experimental or Investigational / Not Medically Necessary](#)^[s]

Revuforj (revumenib) for any other indication or use is considered not medically necessary by the Plan, as it is deemed to be experimental, investigational, unproven, or not medically necessary. Non-covered indications include, but are not limited to, the following:

- Acute promyelocytic leukemia
- Blastic plasmacytoid dendritic cell neoplasm
- Chronic myelogenous leukemia

References

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Appendix A

Table 1: Revuforj (revumenib) Recommended Dosage for Patients 1 Year and Older

| Patient Weight | Without Strong CYP3A4 Inhibitors | With Strong CYP3A4 Inhibitors |
|-----------------|---|--|
| 40 kg or more | 270 mg orally twice daily | 160 mg orally twice daily |
| Less than 40 kg | 160 mg/m ² orally twice daily* | 95 mg/m ² orally twice daily* |

*See Table 2 for the total tablet dosage by BSA (body surface area) for patients weighing less than 40 kg.

Table 2: Revuforj (revumenib) Recommended Dosage using Tablets[^] for Patients Weighing Less than (<) 40 kg

| BSA (m ²) | Revuforj (revumenib) Dosage for 160 mg/m ² | Revuforj (revumenib) Dosage for 95 mg/m ² |
|-----------------------|---|--|
| 1.4 | 220 mg twice daily | 135 mg twice daily |
| 1.3 | 220 mg twice daily | 135 mg twice daily |

| | | |
|-----|--------------------|--------------------|
| 1.2 | 185 mg twice daily | 110 mg twice daily |
| 1.1 | 185 mg twice daily | 110 mg twice daily |
| 1 | 160 mg twice daily | 100 mg twice daily |
| 0.9 | 135 mg twice daily | 75 mg twice daily |
| 0.8 | 135 mg twice daily | 75 mg twice daily |
| 0.7 | 110 mg twice daily | 50 mg twice daily |
| 0.6 | 100 mg twice daily | 50 mg twice daily |
| 0.5 | 75 mg twice daily | 50 mg twice daily |
| 0.4 | 50 mg twice daily | 25 mg twice daily |

^If needed, attain the desired dose by combining different strengths of Revuforj (revumenib) tablets.

Clinical Guideline Revision / History Information

Original Date: 07/01/2026

Reviewed/Revised: