PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Daurismo Prior Authorization Policy
- Daurismo™ (glasdegib tablets – Pfizer)

REVIEW DATE: 01/21/2026

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Daurismo, a hedgehog pathway inhibitor, is indicated, in combination with low dose cytarabine, for the treatment of newly diagnosed **acute myeloid leukemia** in adults who are ≥ 75 years of age or who have comorbidities that preclude use of intensive induction chemotherapy.[1]

Guidelines

Daurismo is addressed in the National Comprehensive Cancer Network (NCCN) guidelines for acute myeloid leukemia (version 3.2026 – November 24, 2025). The guidelines recommend Daurismo with low-dose cytarabine for newly diagnosed patients ≥ 75 years of age, or who have significant comorbid conditions (i.e., severe cardiac disease, Eastern Cooperative Oncology Group performance status ≥ 2, baseline creatinine > 1.3 mg/dL).[2] This recommendation is for lower-intensity treatment induction in patients without isocitrate dehydrogenase 1 (*IDH1*) mutations who are not candidates for intensive remission induction therapy or who decline intensive therapy as "Useful in Certain Circumstances" (category 2A).[2] It is also indicated for follow-up after induction therapy following a response to previous lower intensity therapy with the same regimen (category 2A) and as consolidation

therapy as continuation of low-intensity regimen used for induction in select patients (category 2A).[2]

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Daurismo. All approvals are provided for the duration noted below.

- **Daurismo™ (glasdegib tablets - Pfizer)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. **Acute Myeloid Leukemia.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) Patient is using the medication in combination with cytarabine.

CONDITIONS NOT COVERED

- **Daurismo™ (glasdegib tablets - Pfizer)**

is(are) considered not medically necessary for ANY other use(s).

REFERENCES

1. Daurismo™ tablets [prescribing information]. New York, NY: Pfizer; December 2024.
2. The NCCN Acute Myeloid Leukemia Clinical Practice Guidelines in Oncology (version 3.2026 – November 24, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on January 16, 2026.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	01/17/2024
Annual Revision	No criteria changes.	01/22/2025
Annual Revision	No criteria changes.	01/21/2026