PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Oral) – Qinlock Prior Authorization Policy
- Qinlock® (ripretinib tablets – Deciphera Pharmaceuticals)

REVIEW DATE: 04/08/2026

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

Qinlock, a kinase inhibitor, is indicated for the treatment of advanced **gastrointestinal stromal tumor** in adults who have received prior treatment with three or more kinase inhibitors, including imatinib.[1]

Guidelines

Qinlock is discussed in guidelines from the National Comprehensive Cancer Network (NCCN):

- **Gastrointestinal Stromal Tumor**: NCCN guidelines (version 1.2026 – January 13, 2026) recommend Qinlock for unresectable, progressive, or metastatic disease in the following situations: Qinlock 150 mg daily as second-line therapy for patients who are intolerant of second-line sunitinib as a "Preferred" regimen (category 2A); Qinlock 150 mg daily as fourth-line therapy after therapy with imatinib, sunitinib, and Stivarga® (regorafenib tablets) if not previously received as a "Preferred" regimen" (category 1); Qinlock dose escalation to 150 mg twice daily, if patient has previously been treated with

Qinlock 150 mg daily, is included as an additional option after progression on approved therapies as "Useful in Certain Circumstances"(category 2A). In this setting, imatinib is considered first-line therapy. [2,3]

- **Melanoma: Cutaneous**: NCCN guidelines (version 1.2026 –February 17, 2026) recommend Qinlock as "Useful in Certain Circumstances" for metastatic or unresectable disease with an activating *KIT* mutation as second-line or subsequent therapy for disease progression, intolerance, and/or projected risk of progression with *BRAF*-targeted therapy (category 2A).[2,4]

POLICY STATEMENT

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

- **Qinlock® (ripretinib tablets - Deciphera Pharmaceuticals)**

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. **Gastrointestinal Stromal Tumor.** Approve for 1 year if the patient meets ALL of the following (A, B and C):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has tried imatinib; AND
   - **C)** Patient meets ONE of the following (i or ii):
     - **i.** Patient has tried sunitinib and Stivarga (regorafenib tablets); OR
     - **ii.** Patient is intolerant of sunitinib.

Other Uses with Supportive Evidence

2. **Melanoma, Cutaneous.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has metastatic or unresectable disease; AND
   - **C)** Patient has an activating *KIT* mutation; AND
   - **D)** Patient has tried at least one systemic regimen.
     Note: Examples of a systemic regimen include: Opdivo (nivolumab intravenous infusion) + Yervoy (ipilimumab intravenous infusion), Opdualag (nivolumab/relatlimab-rmbw intravenous infusion), Keytruda (pembrolizumab intravenous infusion), Opdivo, Tafinlar (dabrafenib capsules and oral tablets for suspension) + Mekinist (trametinib tablets and oral solution), Zelboraf (vemurafenib tablets) + Cotellic (cobimetinib tablets), Braftovi (encorafenib capsules) + Mektovi (binimetinib tablets).

CONDITIONS NOT COVERED

- **Qinlock® (ripretinib tablets - Deciphera Pharmaceuticals)**

is(are) considered not medically necessary for ANY other use(s); criteria will be updated as new published data are available.

REFERENCES

1. Qinlock® tablets [prescribing information]. Waltham, MA: Deciphera Pharmaceuticals; May 2025.
2. The NCCN Drugs & Biologics Compendium. © 2026 National Comprehensive Cancer Network. Available at: http://www.nccn.org/. Accessed on April 2, 2026.
3. The NCCN Gastrointestinal Stromal Tumor (GIST) Clinical Practice Guidelines in Oncology (version 1.2026 – January 13, 2026). © 2026 National Comprehensive Cancer Network. Available at: http://www.nccn.org/. Accessed on April 2, 2026.
4. The NCCN Melanoma: Cutaneous Clinical Practice Guidelines in Oncology (version 1.2026 – February 17, 2026). © 2026 National Comprehensive Cancer Network. Available at: http://www.nccn.org/. Accessed on April 2, 2026.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	04/19/2024
Annual Revision	**Gastrointestinal Stromal Tumor:** The brand name Sprycel was removed from the criterion which states patient has tried Sprycel (dasatinib tablets). **Melanoma, Cutaneous:** The following example of systemic regimen in the Note was modified from Opdivo + Opdualag (nivolumab/relatlimab-rmbw intravenous infusion) to Opdualag (nivolumab/relatlimab-rmbw intravenous infusion	04/02/2025
Annual Revision	The name of the policy was changed to as listed. Previously, it was "Oncology – Qinlock." **Gastrointestinal Stromal Tumor:** Ayvakit (avapritinib tablets) was removed from the requirement that was previously worded, "Patient has tried imatinib or Ayvakit (avapritinib tablets)" The option for approval when patient has tried dasatinib was removed.	04/08/2026

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