PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Oral – FMS-Like Tyrosine Kinase 3 Inhibitor) – Rydapt Prior Authorization Policy
- Rydapt® (midostaurin capsules – Novartis)

REVIEW DATE: 03/04/2026

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

Rydapt, a tyrosine kinase inhibitor, is indicated in adults for the following uses:[1]

- **Acute myeloid leukemia,** newly diagnosed, that is FMS-like tyrosine kinase 3 (*FLT3*) mutation-positive as detected by an FDA-approved test, in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation.
  Limitations of use: Rydapt is not indicated as a single-agent induction therapy for treatment of patients with acute myeloid leukemia.
- **Aggressive systemic mastocytosis, systemic mastocytosis with associated hematological neoplasm, or mast cell leukemia**.

Guidelines

Rydapt is discussed in the National Comprehensive Cancer Network (NCCN) guidelines:[2]

- **Acute Myeloid Leukemia:** NCCN guidelines (version 3.2026 – November 24, 2025) recommend Rydapt among the treatment options for induction (category 1) and re-induction, consolidation, and maintenance for patients with *FLT3-ITD/TKD* mutation (category 2A).[3]
- **Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusion:** NCCN guidelines (version 1.2026 – October 3, 2025) recommend Rydapt for patients with *FGFR1* or *FLT3* rearrangements in chronic phase or blast phase (category 2A).[4] Rydapt is also recommended for treatment in combination with induction chemotherapy followed by allogeneic hematopoietic cell transplantation (if eligible) for lymphoid, myeloid or mixed lineage neoplasms with eosinophilia and *FGFR1* or *FLT3* rearrangements in blast phase (category 2A).
- **Systemic Mastocytosis:** NCCN guidelines (version 1.2026 – January 26, 2026) recommend Rydapt for the treatment of aggressive systemic mastocytosis, systemic mastocytosis with an associated hematologic neoplasm, and mast cell leukemia (all category 2A).[5] Rydapt is also recommended for treatment of *KIT* D1816V-negative systemic mastocytosis with advanced disease and next-generation sequencing reveals no alternative (non-Exon 17) *KIT* mutation in Exons 8 through 11 (category 2A). There is a footnote that states patients with alternative *KIT* D816 mutations (e.g. D816H, D816T, D816L) or other mutations in Exon 17 should still follow other treatment algorithms. Rydapt is also recommended for the treatment of symptomatic indolent systemic mastocytosis or smoldering systemic mastocytosis if inadequate response, intolerance/no response, or loss of response to first-line therapy with a clinical trial or Ayvakit® (avapritinib tablets) as "useful in certain circumstances" (category 2A).

POLICY STATEMENT

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

- **Rydapt® (midostaurin capsules - Novartis)**

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 Indications

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 has *FLT3* mutation-positive disease.

2. **Systemic Mastocytosis – Aggressive.** Approve for 1 year if the patient is ≥ 18 years of age.

3. **Systemic Mastocytosis – Mast Cell Leukemia.** Approve for 1 year if the patient is ≥ 18 years of age.

4. **Systemic Mastocytosis Associated with Acute Hematologic Neoplasm.** Approve for 1 year if the patient is ≥ 18 years of age.

Other Uses with Supportive Evidence

5. **Systemic Mastocytosis – Indolent.** 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 symptomatic disease; AND
   C) Patient has tried at least one systemic regimen.
   Note: Example of a systemic regimen includes Ayvakit (avapritinib tablets).

6. **Systemic Mastocytosis – *KIT* D816V-Negative**. 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 advanced systemic mastocytosis; AND
   C) Patient does not have alternative *KIT* mutations in Exons 8-11.

7. **Myeloid or Lymphoid Neoplasms.** 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 eosinophilia; AND
   C) Patient meets ONE of the following (i or ii):
      i. Patient has an *FGFR1* rearrangement; OR
      ii. Patient has an *FLT3* rearrangement.

8. **Systemic Mastocytosis – Smoldering.** 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 has tried at least one systemic regimen.
   Note: Example of a systemic regimen includes Ayvakit (avapritinib tablets).

CONDITIONS NOT COVERED

- **Rydapt® (midostaurin capsules - Novartis)**

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

REFERENCES

1. Rydapt® capsules [prescribing information]. East Hanover, NJ: Novartis; May 2023.
2. The NCCN Drugs & Biologics Compendium. © 2026 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on February 24, 2026. Search term: midostaurin.
3. 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 February 24, 2026.
4. The NCCN Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions Clinical Practice Guidelines in Oncology (version 1.2026 – October 3, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on February 25, 2026.

5. The NCCN Systemic Mastocytosis Clinical Practice Guidelines in Oncology (version 1.2026 – January 26, 2026). © 2026 National Comprehensive Cancer Network. Available at http://www.nccn.org. Accessed on February 25, 2026.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	03/06/2024
Annual Revision	**Indolent Systemic Mastocytosis:** Indication and criteria were added to "Other Uses With Supportive Evidence" based on National Comprehensive Cancer Network (NCCN) guideline updates. **Smoldering Systemic Mastocytosis:** Indication and criteria were added to "Other Uses With Supportive Evidence" based on NCCN guideline updates.	03/12/2025
Update	04/08/2025: The policy name was changed from "Oncology – Rydapt PA Policy" to "Oncology (Oral – FMS-Like Tyrosine Kinase 3 Inhibitor) – Rydapt PA Policy".	N/A
Annual Revision	**Acute Myeloid Leukemia:** The wording of "as detected by an approved test" was removed from the requirement which previously stated that the "patient has *FLT3* mutation-positive disease as detected by an approved test". **Systemic Mastocytosis – Mast Cell Leukemia**: Previously this condition of approval was called "Mast Cell Leukemia." **Systemic Mastocytosis – *KIT* D816V-Negative:** This condition of approval and criteria were added to Other Uses with Supportive Evidence.	03/04/2026