



## PRIOR AUTHORIZATION POLICY

- POLICY:** Oncology (Oral – FMS-Like Tyrosine Kinase 3 Inhibitor) – Xospata Prior Authorization Policy
- Xospata® (gilteritinib tablets – Astellas)

**REVIEW DATE:** 01/21/2026

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### **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**

Xospata, an inhibitor of tyrosine kinases including FMS-like tyrosine kinase 3 (*FLT3*), is indicated for the treatment of relapsed or refractory **acute myeloid leukemia** in adults with an *FLT3* mutation as detected by an FDA-approved test.<sup>1</sup>

### **Guidelines**

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

- **Acute Myeloid Leukemia:** NCCN guidelines (version 3.2026 – November 24, 2025) recommend Xospata in patients with *FLT3*-internal tandem duplication (*FLT3-ITD*) or *FLT3*-tyrosine kinase domain (*FLT3-TKD*) mutation in a variety of clinical settings (category 1 or 2A). (

- **Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions:** NCCN guidelines (version 1.2026 – October 3, 2025) recommend Xospata for the treatment of myeloid/lymphoid neoplasms with eosinophilia and *FLT3* rearrangement in chronic phase or blast phase (category 2A). Xospata is also recommended in combination with acute lymphocytic leukemia- or acute myeloid leukemia-type induction chemotherapy followed by allogeneic hematopoietic stem cell transplantation (if eligible) for lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia and *FLT3* rearrangement in blast phase (category 2A).<sup>3</sup>

## **POLICY STATEMENT**

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

- **Xospata® (gilteritinib tablets - Astellas)** 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  $\geq$  18 years of age; AND
  - B) Disease is *FLT3*-mutation positive.

### **Other Uses with Supportive Evidence**

2. **Myeloid/Lymphoid Neoplasms.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
  - A) Patient is  $\geq$  18 years of age; AND
  - B) Patient has eosinophilia; AND
  - C) Disease is *FLT3*-mutation positive.

## **CONDITIONS NOT COVERED**

- **Xospata® (gilteritinib tablets - Astellas)** is(are) considered not medically necessary for ANY other use(s); criteria will be updated as new published data are available)

## REFERENCES

1. Xospata® tablets [prescribing information]. Northbrook, IL: Astellas Pharma; January 2022.
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.
3. 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 January 16, 2026.

## HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	01/17/2024
Annual Revision	<b>Acute Myeloid Leukemia:</b> Criterion which stated that the patient has relapsed or refractory disease was removed.	01/22/2025
Update	04/08/2025: The policy name was changed from "Oncology – Xospata PA Policy" to "Oncology (Oral – FMS-Like Tyrosine Kinase 3 Inhibitor) – Xospata PA Policy".	N/A
Annual Revision	<b>Acute Myeloid Leukemia:</b> The wording of "as detected by an approved test" was removed from the following requirement, "Disease is <i>FLT3</i> -mutation positive." <b>Myeloid/Lymphoid Neoplasm:</b> The wording of "as detected by an approved test" was removed from the following requirement "Disease is <i>FLT3</i> -mutation positive."	01/21/2026

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