# PRIOR AUTHORIZATION POLICY

**POLICY:** Oncology (Oral – Isocitrate Dehydrogenase 1 Inhibitor) – Rezlidhia Prior Authorization Policy
- Rezlidhia® (olutasidenib capsules – Rigel)

**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

Rezlidhia, an isocitrate dehydrogenase-1 (*IDH1*) inhibitor, is indicated for the treatment of relapsed or refractory **acute myeloid leukemia** with a susceptible *IDH1* mutation as detected by an FDA-approved test in adults.[1]

### Guidelines

Rezlidhia is discussed in guidelines from the National Comprehensive Cancer Network (NCCN). NCCN acute myeloid leukemia guidelines (version 3.2026 – November 24, 2025) recommend Rezlidhia or Tibsovo® (ivosidenib tablets) for patients with relapsed or refractory AML with an *IDH1* mutation (both category 2A).[2] Rezlidhia is also recommended as treatment induction as lower intensity therapy in situations when the patient is intensive induction ineligible or patient declines intensive induction therapy. This recommendation is specifically for those with an *IDH1* mutation in situations where the patient is not eligible for the

preferred regimen and not eligible for Tibsovo due to prolonged QT interval corrected using Fridericia's formula (QTcF) [category 2B]. Preferred regimens are azacitidine + Venclexta® (venetoclax tablets) [category 1], azacitidine + Tibsovo (category 1), and decitabine + Venclexta.

## POLICY STATEMENT

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

- **Rezlidhia® (olutasidenib capsules - Rigel)**

**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 ALL of the following (A, B, and C):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient meets one of the following (i or ii):
     - **i.** Patient has relapsed or refractory disease; OR
     - **ii.** Patient meets ALL of the following (a, b and c):
       - **a)** Patient is not a candidate for intensive induction therapy; AND
       - **b)** Patient is not a candidate for azacitidine, decitabine, or Venclexta (venetoclax tablets); AND
       - **c)** Patient is not a candidate for Tibsovo (ivosidenib tablets); AND
   - **C)** Patient has isocitrate dehydrogenase-1 (*IDH1*) mutation positive disease.

## CONDITIONS NOT COVERED

- **Rezlidhia® (olutasidenib capsules - Rigel)**

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

## REFERENCES


1. Rezlidhia® capsules [prescribing information]. San Francisco, CA: Rigel; April 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 21, 2026.


## HISTORY

| Type of Revision | Summary of Changes | Review Date |
|---|---|---|

| | | |
|---|---|---|
| Annual Revision | No criteria changes. | 12/13/2023 |
| Annual Revision | No criteria changes. | 01/08/2025 |
| Update | 04/08/2025: The policy name was changed from "Oncology – Rezlidhia PA Policy" to "Oncology (Oral - Isocitrate Dehydrogenase 1 Inhibitor) – Rezlidhia PA Policy" | N/A |
| Annual Revision | **Acute Myeloid Leukemia:** An option for approval was added when patient is not a candidate for intensive induction therapy; azacitidine, decitabine, or Venclexta (venetoclax tablets); and Tibsovo (ivosidenib tablets). The following requirement was changed from "patient has isocitrate dehydrogenase-1 (*IDH1*) mutation positive disease as detected by an approved test" to "Patient has isocitrate dehydrogenase-1 (*IDH1*) mutation positive disease". | 01/21/2026 |