



PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Revuforj Prior Authorization Policy

- Revuforj™ (revumenib tablets – Syndax)

REVIEW DATE: 10/29/2025

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

Revuforj, a menin inhibitor, is indicated in adults and pediatric patients ≥ 1 year of age for the following uses¹:

- Treatment of relapsed or refractory **acute leukemia** with a lysine methyltransferase 2A (**KMT2A**) gene translocation as determined by an FDA-authorized test;
- Treatment of relapsed or refractory **acute myeloid leukemia (AML)** with susceptible nucleophosmin 1 (**NPM1**) mutation who have no satisfactory alternative treatment options.

Guidelines

Revuforj is addressed in National Comprehensive Cancer Network (NCCN) guidelines:

- **Acute Lymphoblastic Leukemia (ALL):** NCCN guidelines (version 2.2025 – June 27, 2025) recommend Revuforj as an "Other Recommended Regimen" for patients with relapsed/refractory **KMT2A**-rearranged Philadelphia chromosome-negative B-ALL and T-cell ALL (both category 2A).²

- **Pediatric ALL:** NCCN guidelines (version 1.2026 – August 11, 2025) recommend Revuforj as an “Other Recommended Regimen” for patients with relapsed/refractory *KMT2A*-rearranged *BCR::ABL1*-negative ALL and T-cell ALL (both category 2A).³
- **AML:** NCCN guidelines (version 2.2026 – October 2, 2025) recommend Revuforj for the treatment of patients with relapsed/refractory *KMT2A*-rearrangement or *NPM1* mutation (category 2A recommendation).⁴

POLICY STATEMENT

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

- **Revuforj™ (revumenib tablets – Syndax)**

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 Leukemia.** Approve for 1 year if the patient meets BOTH of the following (A and B):
 - A) Patient has relapsed or refractory disease; AND**
 - B) Patient meets ONE of the following (i or ii):**
 - i. Patient has acute myeloid leukemia and meets ONE of the following (a or b):**
 - a) The disease is positive for a lysine methyltransferase 2A (*KMT2A*) gene translocation or rearrangement; OR**
 - b) The disease is positive for a susceptible nucleophosmin 1 (*NPM1*) mutation.; OR**
 - ii. Patient meets BOTH of the following (a and b):**
 - a) Patient has acute lymphoblastic leukemia; AND**
 - b) The disease is positive for a lysine methyltransferase 2A (*KMT2A*) gene translocation or rearrangement.**

CONDITIONS NOT COVERED

- **Revuforj™ (revumenib tablets – Syndax)**

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

REFERENCES

1. Revuforj™ tablets [prescribing information]. Waltham MA: Syndax; November 2024.
2. The NCCN Acute Lymphoblastic Leukemia Clinical Practice Guidelines in Oncology (version 2.2025 – June 27, 2025) © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on October 27, 2025.
3. The NCCN Pediatric Acute Lymphoblastic Leukemia Clinical Practice Guidelines in Oncology (version 1.2026 – August 11, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on October 27, 2025.
4. The NCCN Acute Myeloid Leukemia Clinical Practice Guidelines in Oncology (version 2.2026 – October 2, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on October 27, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	11/20/2024
DEU Update	12/24/2024: The Guidelines section has been updated with National Comprehensive Cancer Network (NCCN) recommendations for acute myeloid leukemia (AML), acute lymphoblastic leukemia (ALL), and pediatric ALL; all of which address Revuforj.	--
Annual Revision	Acute Leukemia: The age requirement (≥ 1 year old) was removed. The wording "rearrangement" was added to the requirement, "The disease is positive for a lysine methyltransferase 2A (<i>KMT2A</i>) gene translocation or rearrangement." For a patient with disease that is positive with lysine methyltransferase 2A (<i>KMT2A</i>) gene translocation or rearrangement, the requirement that the patient has acute lymphoblastic leukemia or acute myeloid leukemia was added. For a patient with acute myeloid leukemia, an additional option for approval was added if the disease has a susceptible nucleophosmin 1 (<i>NPM1</i>) mutation.	10/29/2025

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