PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Tibsovo Prior Authorization Policy
- Tibsovo® (ivosidenib tablets –Servier/Les)

REVIEW DATE: 03/12/2025

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 AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. 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

Tibsovo, an isocitrate dehydrogenase-1 (*IDH1*) inhibitor, is indicated for the treatment of cancers with a susceptible *IDH1* mutation as detected by an FDA-approved test:[1]

- **Acute myeloid leukemia, newly diagnosed disease, in combination with azacitidine or as monotherapy,** in patients who are ≥ 75 years of age or who have comorbidities that preclude use of intensive induction chemotherapy.
- **Acute myeloid leukemia, relapsed or refractory disease**, in adults.
- **Cholangiocarcinoma, locally advanced or metastatic**, in adults who have been previously treated.
- **Myelodysplastic syndrome, relapsed or refractory disease**, in adults.

Guidelines

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

- **Acute Myeloid Leukemia:** NCCN guidelines (version 2.2025 – January 27, 2025) recommend single-agent Tibsovo (category 2A) or Tibsovo + azacitidine (category 1) for patients with an *IDH1* mutation for treatment induction, follow-up after induction therapy and consolidation therapy. Single-agent

Tibsovo is recommended for patients with an *IDH1* mutation who have relapsed or refractory disease (category 2A).[3]

- **Bone Cancer:** NCCN guidelines (version 2.2025 – February 28, 2025) recommend Tibsovo for conventional (grades 1 to 3) chondrosarcoma and dedifferentiated chondrosarcoma in patients with susceptible *IDH1* mutations as "useful in certain circumstances" (category 2A).[5]
- **Central Nervous System Cancers:** NCCN guidelines (version 4.2024 – January 21, 2025) recommend Tibsovo for *IDH1* mutant oligodendroglioma (category 2A) and *IDH1* mutant astrocytoma (category 2A/2B) [6]
- **Cholangiocarcinoma:** NCCN guidelines for biliary tract cancer (version 6.2024 – January 10, 2025) cite Tibsovo as "useful in certain circumstances" for patients with cholangiocarcinoma with *IDH1* mutations as subsequent-line therapy if there is disease progression (category 1).[4]
- **Myelodysplastic Syndromes:** NCCN guidelines (version 1.2024 – February 12, 2024) recommend Tibsovo for patients with myelodysplastic syndrome with *IDH1* mutation when patients has not experienced a response to other therapies (category 2A/2B).[7]

POLICY STATEMENT

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

- **Tibsovo® (ivosidenib tablets - Servier/Les)**

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 isocitrate dehydrogenase-1 (*IDH1*) mutation-positive disease as detected by an approved test.

2. **Cholangiocarcinoma.** 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 isocitrate dehydrogenase-1 (*IDH1*) mutation-positive disease; AND
   C) Patient has been previously treated with at least one chemotherapy regimen.
   Note: Examples of a chemotherapy regimen include one or more of the following agents: cisplatin, Imfinzi (durvalumab intravenous infusion), gemcitabine, Keytruda (pembrolizumab intravenous infusion), 5-fluorouracil, oxaliplatin, capecitabine.

3. **Myelodysplastic Syndrome.** 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 isocitrate dehydrogenase-1 (*IDH1*) mutation-positive disease; AND
C) Patient has relapsed or refractory disease.

Other Uses with Supportive Evidence

4. **Bone Cancer.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   A) Patient has chondrosarcoma; AND
   B) Patient has isocitrate dehydrogenase-1 (*IDH1*) mutation-positive disease.

5. **Central Nervous System Cancer**. 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 meets ONE of the following (i or ii):
      i. Patient has oligodendroglioma; OR
      ii. Patient has astrocytoma.

CONDITIONS NOT COVERED

- **Tibsovo® (ivosidenib tablets - Servier/Les)**

is(are) considered experimental, investigational or unproven for ANY other use(s); criteria will be updated as new published data are available.

REFERENCES

1. Tibsovo® tablets [prescribing information]. Boston, MA: Servier/Les; October 2023.
2. The NCCN Drugs & Biologics Compendium. © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on March 10, 2025. Search term: ivosidenib.
3. The NCCN Acute Myeloid Leukemia Clinical Practice Guidelines in Oncology (version 2.2025 – January 27, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on March 10, 2025.
4. The NCCN Biliary Tract Cancers Clinical Practice Guidelines in Oncology (version 6.2024 – January 10, 2025). © 2025 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed on March 10, 2025.
5. The NCCN Bone Cancers Clinical Practice Guidelines in Oncology (version 2.2025 – February 28, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on March 10, 2025.
6. The NCCN Central Nervous System Cancers Clinical Practice Guidelines in Oncology (version 4.2024 – January 21, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on March 10, 2025.
7. The NCCN Myelodysplastic Syndromes Clinical Practice Guidelines in Oncology (version 2.2025 – January 17, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on March 10, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	03/08/2023

Selected Revision	**Central Nervous System Cancer**: Indication and criteria were added based on changes in NCCN guidelines.	04/19/2023
Selected Revision	**Myelodysplastic Syndrome**: Indication and criteria were added to FDA-approved indications section.	11/01/2023
Annual Revision	No criteria changes.	03/06/2024
Annual Revision	**Cholangiocarcinoma:** The note regarding examples of a chemotherapy regimen was revised. Previously, the note stated, "Examples are gemcitabine + cisplatin; Imfinzi (durvalumab intravenous infusion) + gemcitabine + cisplatin, 5-fluorouracil + oxaliplatin or cisplatin; capecitabine + oxaliplatin or cisplatin; gemcitabine + Abraxane (paclitaxel protein-bound particles intravenous infusion) or capecitabine or oxaliplatin; and FOLFOX (5-fluorouracil, leucovorin, and oxaliplatin)." The revised note now states, "Examples of a chemotherapy regimen include one or more of the following agents: cisplatin, Imfinzi (durvalumab intravenous infusion), gemcitabine, Keytruda (pembrolizumab intravenous infusion), 5-fluorouracil, oxaliplatin, capecitabine" **Central Nervous System Cancer:** The requirement that the patient has recurrent or progressive disease has been removed. The requirement of "World Health Organization (WHO) grade 2 or 3" was removed for a patient with oligodendroglioma. The requirement of "WHO grade 2" was removed for a patient with astrocytoma.	03/12/2025