

DRUG POLICY

Revuforj® (revumenib)

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

The intent of the policy is to provide coverage consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines. The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Revuforj is indicated for the treatment of relapsed or refractory acute leukemia with a lysine methyltransferase 2A gene (KMT2A) translocation in adult and pediatric patients 1 year and older.

Revuforj is indicated for the treatment of relapsed or refractory acute myeloid leukemia (AML) with a susceptible nucleophosmin 1 (NPM1) mutation in adults and pediatric patients 1 year and older who have no satisfactory alternative treatment options.

Compendial Uses

Acute Lymphoblastic Leukemia (ALL)

Acute Myeloid Leukemia (AML)

POLICY

Required Documentation

Submission of the following information is necessary to initiate the prior authorization review:

1. KMT2A translocation status, where applicable
2. NPM1 mutation status, where applicable

Criteria for Initial Approval

Acute Leukemias

Authorization of 12 months may be granted for treatment of relapsed or refractory acute leukemia when both the following criteria are met:

1. Member has a KMT2A translocation
2. Requested medication will be used as a single agent when the member does not have BCR::ABL1-positive B-cell acute lymphoblastic leukemia (B-ALL)

Authorization of 12 months may be granted for the treatment of relapsed or refractory acute myeloid leukemia (AML) with a NPM1 mutation as a single agent.

Continuation of Therapy

Acute Leukemias

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the Criteria for Initial Approval section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

Other

Revuforj (revuminib) is considered **not medically necessary** for members who do not meet the criteria set forth above.

Medication	Standard Limit	FDA Recommended Dosing
Revuforj 25 mg tablet	240 tablets per 30 days	Without strong CYP3A4 inhibitors • ≥ 40 kg: 270 mg orally twice daily • < 40 kg: 160 mg/m² orally twice daily With strong CYP3A inhibitors • ≥ 40 kg: 160 mg orally twice daily • < 40 kg: 95 mg/m² orally twice daily <i>Dose reductions may be needed for adverse reactions</i>
Revuforj 110 mg tablet	120 tablets per 30 days	
Revuforj 160 mg tablet	60 tablets per 30 days	

PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

- N/A

REFERENCES

- Revuforj [package insert]. Waltham, MA: Syndax Pharmaceuticals, Inc.; April 2025.
- The NCCN Drugs & Biologics Compendium® © 2025 National Comprehensive Cancer Network, Inc. <http://www.nccn.org>. Accessed July 7, 2025

POLICY HISTORY

Policy #: 05.05.75

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