

DRUG POLICY

Modeyso™ (dordaviprone)

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

Modeyso is indicated for the treatment of adult and pediatric patients 1 year of age and older with diffuse midline glioma harboring an H3 K27M mutation with progressive disease following prior therapy.

POLICY

Required Documentation

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

1. Laboratory values, chart notes, or medical records documenting H3 K27M mutation status

Criteria for Initial Approval

Diffuse Midline Glioma

Authorization of 12 months may be granted for the treatment of diffuse midline glioma, when all of the following criteria are met:

1. Member is 1 year of age or older
2. The disease harbors an H3 K27M mutation
3. Member experienced recurrence or progression following prior therapy

Continuation of Therapy

Diffuse Midline Glioma

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

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

Dosing and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Quantity Limits Apply

Medication	Standard Limit	FDA Recommended Dosing
Modeyso (dordaviprone) 125 mg capsule	20 capsules per 28 days	Administer orally once weekly. Adult patients: 625 mg once weekly Weight based dosing for pediatric patients: - 10 to <12.5 kg: 125 mg once weekly - 12.5 to <27.5 kg: 250 mg once weekly - 27.5 to <42.5 kg: 375 mg once weekly - 42.5 to <52.5 kg: 500 mg once weekly - ≥52.5 kg: 625 mg once weekly

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.

REFERENCES

Modeyso [package insert]. Palo Alto, CA: Jazz Pharmaceuticals, Inc.; August 2025.

The NCCN Drugs & Biologics Compendium™ © 2025 National Comprehensive Cancer Network, Inc.
<https://www.nccn.org> Accessed September 3, 2025.

POLICY HISTORY

Policy #: 05.06.06

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Reviewed: August 2026

Revised:

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