# PRIOR AUTHORIZATION POLICY

**POLICY:** Oncology – Daurismo Prior Authorization Policy
- Daurismo™ (glasdegib tablets – Pfizer)

**REVIEW DATE:** 01/17/2024

---

## OVERVIEW

Daurismo, a hedgehog pathway inhibitor, is indicated, in combination with low-dose cytarabine, for the treatment of newly diagnosed **acute myeloid leukemia** in adults who are ≥ 75 years of age or who have comorbidities that preclude use of intensive induction chemotherapy.[1]

## Guidelines

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

- **Acute Myeloid Leukemia:** Guidelines (version 6.2023 – October 24, 2023) recommend Daurismo with low-dose cytarabine for newly diagnosed patients ≥ 75 years of age, or who have significant comorbid conditions (i.e., severe cardiac disease, Eastern Cooperative Oncology Group performance status ≥ 2, baseline creatinine > 1.3 mg/dL).[2] This recommendation is for treatment induction in patients without actionable mutations who are not candidates for intensive remission induction therapy or who decline intensive therapy as "Other Recommended Regimen" (category 2A).[2] It is also indicated for follow-up after induction therapy following a response to previous lower intensity therapy with the same regimen (category 2A) and as consolidation therapy as continuation of low-intensity regimen used for induction in select patients (category 2A).[2] Daurismo is also indicated for relapsed/refractory disease as a component of repeating the initial successful induction regimen if late relapse (≥ 12 months since induction regimen), if it is not administered continuously and not stopped due to development of clinical resistance (category 2A).

## POLICY STATEMENT

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

**Automation**: None.

## RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Daurismo is recommended in those who meet the following criteria:

### FDA-Approved Indication

1. **Acute Myeloid Leukemia.** Approve for 1 year if the patient meets the following (A and B):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient is using the medication in combination with cytarabine.

## CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Daurismo is not recommended in the following situations:

**1.** Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

## REFERENCES

1. Daurismo™ tablets [prescribing information]. New York, NY: Pfizer; March 2023.
2. The NCCN Acute Myeloid Leukemia Clinical Practice Guidelines in Oncology (version 6.2023 – October 24, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on January 12, 2024.