Reference number(s)
6737-A

Specialty Guideline Management
Revuforj

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Revuforj	revumenib

Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit 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.

Documentation

Submission of the following information is necessary to initiate the prior authorization review: KMT2A translocation status

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Coverage Criteria

Acute Leukemia

Authorization of 12 months may be granted for treatment of relapsed or refractory acute leukemia with a KMT2A translocation.

Continuation of Therapy

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

References

1. Revuforj [package insert]. Waltham, MA: Syndax Pharmaceuticals, Inc.; November 2024.