Reference number(s)
7498-A

Specialty Guideline Management
Decnupaz

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
Decnupaz	pivekimab sunirine-pvzy

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 Indication[1]

Decnupaz is indicated for the treatment of adult patients with blastic plasmacytoid dendritic cell neoplasm (BPDCN).

All other indications are considered experimental/investigational and not medically necessary.

Documentation

Submission of the following information is necessary to initiate the prior authorization review: medical record documentation that supports a confirmed diagnosis of BPDCN.

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Coverage Criteria

Blastic Plasmacytoid Dendritic Cell Neoplasm (BPDCN)[1]

Authorization of 12 months may be granted for the treatment of BPDCN when used as a single agent.

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 disease progression or unacceptable toxicity while on the current regimen.

References

1. Decnupaz [package insert]. North Chicago, IL: AbbVie Inc.; May 2026.