

Applicable Drugs: Inqovi (decitabine and cedazuridine)

Preferred: N/A

Non-preferred: N/A

Date of Origin: 2/26/2021

Date Last Reviewed / Revised: 3/14/2026

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I through V are met)

- I. Documentation of the following FDA-approved diagnoses AND must meet all criteria listed under the applicable diagnosis:

FDA-Approved Indication(s)

A. Myelodysplastic syndromes (MDS)

1. Documentation of any of the following French-American-British (FAB) classification subtypes:
 - a) Refractory anemia
 - b) Refractory anemia with ringed sideroblasts
 - c) Refractory anemia with excess blasts
 - d) Chronic myelomonocytic leukemia (CMML)
2. Documented classification of one of the following (a or b):
 - a) International Prognostic Scoring System (IPSS): intermediate-1-, intermediate-2-, or high-risk disease
 - b) Revised International Prognostic Scoring System (IPSS-R): intermediate-, high-, or very-high-risk disease
3. Documented treatment failure, intolerance, or contraindication to all the following:
 - a) Azacitidine
 - b) Decitabine

- II. Minimum age requirement: 18 years old

- III. Treatment must be prescribed by or in consultation with an oncologist or hematologist.

- IV. Request is for a medication with the appropriate FDA labeling, or its use is supported by current National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1 or 2A.

- V. Refer to the plan document for the list of preferred products. If the requested agent is not listed as a preferred product, must have documented treatment failure or contraindication to the preferred product(s).

EXCLUSION CRITERIA

- N/A

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- Up to 5 tablets per 28 days.

APPROVAL LENGTH

- **Authorization:** 6 months.
- **Re-Authorization:** 1 year. An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

APPENDIX

- N/A

REFERENCES

1. Inqovi. Prescribing information. Taiho Oncology; 2024. Accessed March 3, 2026. https://taihocorporate-media-release.s3.us-west-2.amazonaws.com/documents/INQOVI_Prescribing_Information.pdf
2. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Myelodysplastic Syndromes. Version 3.2026. Updated January 12, 2026. Accessed March 14, 2026. https://www.nccn.org/professionals/physician_gls/pdf/mds.pdf

DISCLAIMER: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.