Clinical Policy: Quizartinib (Vanflyta)

Reference Number: CP.PHAR.646
Effective Date: 12.01.23
Last Review Date: 11.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Quizartinib (Vanflyta®) is a kinase inhibitor.

FDA Approved Indication(s)

Vanflyta is indicated in combination with standard cytarabine and anthracycline induction and cytarabine consolidation, and as maintenance monotherapy following consolidation chemotherapy, for the treatment of adult patients with newly diagnosed acute myeloid leukemia (AML) that is FLT3 internal tandem duplication (ITD)-positive as detected by an FDA-approved test.

Limitation(s) of use: Vanflyta is not indicated as maintenance monotherapy following allogeneic hematopoietic stem cell transplantation (HSCT); improvement in overall survival with Vanflyta in this setting has not been demonstrated.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Vanflyta is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Acute Myeloid Leukemia (must meet all)**:**

1. Diagnosis of AML;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Vanflyta is prescribed as any of the following (a, b, c, or d):
   a. Induction therapy in combination with cytarabine and an anthracycline (e.g., daunorubicin, idarubicin);
   b. Consolidation therapy in combination with cytarabine;
   c. Maintenance therapy as a single agent and one of the following (i, ii, or iii):
      i. Following consolidation chemotherapy;
      ii. Member is post-allogeneic hematopoietic cell transplantation and in remission;
      iii. Member previously received a FLT3 inhibitor (e.g., Rydapt®, Xospata®) and does not have an allogeneic hematopoietic cell transplantation planned;
   d. Therapy as a single agent for relapsed/refractory disease;

5. Presence of FLT3 ITD mutation;
6. For Vanflyta requests, member must use generic quizartinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
7. Request meets one of the following (a or b):*
   a. Dose does not exceed 2 tablets and one of the following (i, ii, or iii);
      i. For induction therapy: 35.4 mg on days 8-21 for two 28-day cycles;
      ii. For consolidation therapy: 35.4 mg on days 6-19 for four 28-day cycles;
      iii. For maintenance monotherapy: 53 mg per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months

B. Myeloid/Lymphoid Neoplasm (off-label) (must meet all)**:**
1. Diagnosis of myeloid/lymphoid or mixed phenotype neoplasms with eosinophilia in blast phase or chronic phase;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Presence of FLT3 rearrangement;
5. For Vanflyta requests, member must use generic quizartinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).*

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months

C. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Vanflyta for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Vanflyta requests, member must use generic quizartinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed both of the following (i and ii):
      i. 53 mg per day;
      ii. 2 tablets per day;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AML: acute myeloid leukemia
FDA: Food and Drug Administration
FLT3: FMS-like tyrosine kinase 3
HSCT: hematopoietic stem cell transplantation
ITD: internal tandem duplication
NCCN: National Comprehensive Cancer Network
QTcF: QT interval corrected by Fridericia's formula

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): patients with severe hypokalemia, severe hypomagnesemia, long QT syndrome, or in patients with a history of ventricular arrhythmias or torsades de pointes.
- Boxed warning(s): QT prolongation, torsades de pointes, and cardiac arrest

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
AML	*Induction therapy for up to two 28-day cycles* 35.4 mg PO QD starting on Day 8 (for 7 + 3 regimen) for two weeks per cycle (Days 8 to 21) *Consolidation therapy for up to four 28-day cycles* 35.4 mg PO QD starting on Day 6 for two weeks per cycle (Days 6 to 19) *Maintenance therapy for up to thirty-six 28-day cycles* • 26.5 mg PO QD on Days 1 through 14 of first cycle if QTcF ≤ 450 ms. • Increase dose to 53 mg PO QD on Day 15 of first cycle if QTcF ≤ 450 ms. • Maintain 26.5 mg PO QD if QTcF > 500 ms during induction or consolidation.	Varies

VI. Product Availability
Oral tablets: 17.7 mg, 26.5 mg

VII. References
1. Vanflyta Prescribing Information. Basking Ridge, NJ: Daiichi Sankyo, Inc.; April 2026. Available at: https://daiichisankyo.us/prescribing-information-portlet/getPIContent?productName=Vanflyta&inline=true. Accessed July 09, 2025.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed August 15, 2026.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	08.25.23	11.23
4Q 2024 annual review: removed exclusion for use as maintenance monotherapy following allogeneic HSCT as this is supported for off-label use per NCCN; references reviewed and updated.	07.17.24	11.24
4Q 2025 annual review: revised AML initial approval duration to 12 months; for AML added option for relapsed/refractory disease	07.09.25	11.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
treatment and for maintenance therapy as a single agent, added options of post-allogeneic hematopoietic cell transplantation and previous receipt a FLT3 inhibitor per NCCN; added off-label criteria for lymphoid, myeloid or mixed phenotype neoplasms with eosinophilia per NCCN; references reviewed and updated.		
4Q 2026 annual review: added single agent therapy requirement for relapsed/refractory AML per NCCN; for continued therapy, revised "AML" to "a covered indication;" added ICHRA line of business; references reviewed and updated.	07.08.26	11.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to

recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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