PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Modeyso Prior Authorization Policy
- Modeyso™ (dordaviprone capsules– Jazz)

REVIEW DATE: 08/13/2025; selected revision 09/10/2025

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Modeyso, a protease activator, is indicated for the treatment of diffuse midline **glioma harboring a histone 3 (H3) K27M mutation** in adult and pediatric patients ≥ 1 year of age with progressive disease following prior therapy.[1]

Guidelines

The National Comprehensive Cancer Network (NCCN) guidelines on central nervous system (CNS) cancers (version 2.2025 – August 28, 2025) recommend Modeyso for recurrent or progressive high-grade glioma with H3 K27M mutation as "Useful in Certain Circumstances (category 2A).[2] For H3-mutated high-grade unmethylated tumors, NCCN recommends clinical trial, standard radiation therapy (category 2A), standard radiation therapy + concurrent and adjuvant temozolomide (category 2B), or standard radiation therapy + adjuvant temozolomide (category 2B). For recurrent diffuse H3-mutated high-grade glioma, the recommendation is to consider clinical trials, systemic therapy, surgery for symptomatic, large lesions, or palliative/best

supportive care if the patient has a poor performance status. NCCN guidelines for pediatric CNS cancers (version 3.2025 – September 2, 2025) recommend Modeyso for recurrent or progressive diffuse high-grade glioma with a H3 K27M mutation (category 2A).[3] There is a footnote that states the FDA approval is based on adult patient data and includes very limited efficacy data in pediatric patients.

POLICY STATEMENT

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

- **Modeyso™ (dordaviprone capsules(Jazz)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. **High-Grade Glioma.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   Note: Examples of high-grade glioma include World Health Organization (WHO) Grade 3 or 4 gliomas, such as diffuse midline glioma or glioblastoma.
   A) Patient has a histone 3 (H3) K27M mutation; AND
   B) Patient has recurrent or progressive disease; AND
   C) Patient has received at one least prior therapy.
   Note: Examples of prior therapy include radiation, temozolomide, procarbazine, lomustine, or vincristine.

CONDITIONS NOT COVERED

- **Modeyso™ (dordaviprone capsules(Jazz)**

is(are) considered not medically necessary for ANY other use(s); criteria will be updated as new published data are available.

REFERENCES

1. Modeyso™ capsules [prescribing information]. Palo Alto, CA: Jazz Pharmaceuticals; August 2025.
2. The NCCN Central Nervous System Cancers Clinical Practice Guidelines in Oncology (version 2.2025 – August 28, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on August 29, 2025.
3. The NCCN Pediatric Central Nervous System Cancers Clinical Practice Guidelines in Oncology (version 3.2025 – September 2, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on September 3, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	08/13/2025
Selected Revision	**High-Grade Glioma**: Previously this condition of approval was worded as "Diffuse Midline Glioma." A note was added with examples of high-grade glioma. An option for approval was added for a patient with recurrent disease.	09/10/2025