

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

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| Program Number | 2026 P 1465-2 |
| Program | Prior Authorization/Notification |
| Medication | Revuforj® (revumenib) |
| P&T Approval Date | 1/2025, 1/2026 |
| Effective Date | 4/1/2026 |

1. Background:

Revuforj (revumenib) is a menin inhibitor 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, and for the treatment of relapsed or refractory acute myeloid leukemia (AML) with a susceptible nucleophosmin 1 (NPM1) mutation in adult and pediatric patients 1 year and older who have no satisfactory alternative treatment options.

Coverage Information:

Members will be required to meet the criteria below for coverage. For members under the age of 19 years, the prescription will automatically process without a coverage review.

Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances. Some states also mandate usage of other Compendium references. Where such mandates apply, they supersede language in the benefit document or in the notification criteria.

2. Coverage Criteria ^a:

A. Patients less than 19 years of age

1. **Revuforj** will be approved based on the following criterion:

- a. Patient is less than 19 years of age

Authorization will be issued for 12 months.

B. Acute Lymphoblastic Leukemia/Acute Myeloid Leukemia

1. Initial Authorization

a. **Revuforj** will be approved based on one of the following criteria:

(1) All of the following:

- (a) Diagnosis of acute lymphoblastic leukemia (ALL)

-AND-

- (b) Disease is relapsed or refractory

-AND-

- (c) Positive for lysine methyltransferase 2A gene (KMT2A) translocation

-OR-

- (2) **All** of the following:

- (a) Diagnosis of acute myeloid leukemia (AML)

-AND-

- (b) Disease is relapsed or refractory

-AND-

- (c) **One** of the following:

- i. Positive for nucleophosmin 1 (NPM1) mutation
ii. Positive for lysine methyltransferase 2A gene (KMT2A) translocation

Authorization will be issued for 12 months.

2. **Reauthorization**

- a. **Revuforj** will be approved based on the following criterion:

- (1) Patient does not show evidence of progressive disease while on Revuforj therapy

Authorization will be issued for 12 months.

C. **NCCN Recommended Regimens**

The drug has been recognized for treatment of the cancer indication by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B

Authorization will be issued for 12 months.

^a State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. **Additional Clinical Rules:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.



- Supply limits may be in place.

4. References:

1. Revuforj [package insert]. Syndax Pharmaceuticals, Inc; Waltham, MA; October 2025.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed November 18, 2025.

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| Program | Prior Authorization/Notification - Revuforj® (revumenib) |
| Change Control | |
| 1/2025 | New program |
| 1/2026 | Annual review. Added criteria for new indication per FDA label. Updated references. |