Inqovi (decitabine and cedazuridine)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	1 year

Medications	Quantity Limit
Inqovi (decitabine and cedazuridine)	May be subject to quantity limit

APPROVAL CRITERIA

Requests for Inqovi (decitabine and cedazuridine) may be approved if the following criteria are met:

I. Individual has a diagnosis of myelodysplastic syndrome (MDS) or myelodysplastic/myeloproliferative neoplasm (MDS/MPN) [including chronic myelomonocytic leukemia (CMML)]; **AND**
II. Individual has intermediate to high-risk disease; **OR**
III. Individual is using as a substitute for intravenous decitabine (NCCN 2A).

Key References:

1. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Updated periodically.
2. DrugPoints® System [electronic version]. Truven Health Analytics, Greenwood Village, CO. Updated periodically.
3. Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2025; Updated periodically.
4. Garcia-Manero, Guillermo et al. "Oral decitabine-cedazuridine versus intravenous decitabine for myelodysplastic syndromes and chronic myelomonocytic leukaemia (ASCERTAIN): a registrational, randomised, crossover, pharmacokinetics, phase 3 study." *The Lancet. Haematology* vol. 11,1 (2024): e15-e26. doi:10.1016/S2352-3026(23)00338-1
5. NCCN Clinical Practice Guidelines in Oncology™. © 2025 National Comprehensive Cancer Network, Inc. For additional information visit the NCCN website: http://www.nccn.org/index.asp. Accessed on January 12, 2025.
    a. Myelodysplastic Syndromes. V1.2025. Revised November 15, 2024