

<b>Clinical Policy Title:</b>	ripretinib
<b>Policy Number:</b>	RxA.646
<b>Drug(s) Applied:</b>	Qinlock®
<b>Original Policy Date:</b>	09/14/2020
<b>Last Review Date:</b>	12/11/2025
<b>Line of Business Policy Applies to:</b>	All lines of business (except Medicare)

## Criteria

### I. Initial Approval Criteria

#### A. Advanced Gastrointestinal Stromal Tumor (must meet all):

1. Diagnosis of locally advanced gastrointestinal stromal tumor;
2. Trial and failure of at least three (3) prior kinase inhibitor therapies, including imatinib, unless contraindicated or clinically significant adverse effects experienced;
3. Member has an ECOG performance status of 0-2;
4. Member does not have active central nervous system metastases.

#### Approval Duration

**All lines of business (except Medicare):** 6 months

### II. Continued Therapy Approval

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

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

#### Approval Duration

**All lines of business (except Medicare):** 12 months

## References

1. National Comprehensive Cancer Network. Gastrointestinal Stromal Tumors. Version 2.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/gist.pdf](https://www.nccn.org/professionals/physician_gls/pdf/gist.pdf). Accessed March 21, 2025.
2. National Comprehensive Cancer Network. Cutaneous Melanoma. Version 2.2025. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/cutaneous\\_melanoma.pdf](https://www.nccn.org/professionals/physician_gls/pdf/cutaneous_melanoma.pdf). Accessed March 21, 2025.
3. ECOG Performance status. Available at: <https://ecog-acrin.org/resources/ecog-performance-status>. Accessed March 21, 2025.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	08/2020	09/14/2020
Policy was reviewed: 1. Initial Approval Criteria I.A.5 was updated to include "Member has an ECOG performance status of 0- 2".	07/09/2021	09/14/2021

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

<ol style="list-style-type: none"> <li>2. Continued Therapy Approval Criteria II.A was updated from “All Indications in Section I” to “Advanced Gastrointestinal Stromal Tumor”.</li> <li>3. Continued Therapy Approval Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...".</li> <li>4. References were reviewed and updated.</li> </ol>		
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Initial Approval Criteria, I.A.1: Updated indication from “Diagnosis of advanced GIST” to “Diagnosis of locally advanced, unresectable or metastatic GIST”.</li> <li>2. Initial Approval Criteria, I.A.4: Updated trial and failure criteria from “Member has received 3 or more prior kinase inhibitor therapies, including imatinib unless contraindicated or clinically significant adverse effects experienced” to “Trial and failure of at least three (3) prior kinase inhibitor therapies, including imatinib, unless contraindicated or clinically significant adverse effects experienced”.</li> <li>3. References were reviewed and updated.</li> </ol>	06/30/2022	07/18/2022
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Initial Approval Criteria, I.A.1: Updated diagnosis criteria to include “recurrent, progressive” disease state.</li> <li>2. Initial Approval Criteria, I.A.6: Updated to include new criteria pertaining to indication Advanced GIST, Member does not have active central nervous system metastases.</li> <li>3. Initial Approval Criteria, I.B: Updated to include off label approval criteria for indication, Cutaneous Melanoma (off-label).</li> <li>4. References were reviewed and updated.</li> </ol>	05/29/2023	07/13/2023
<p>Policy was reviewed.</p>	10/19/2023	10/19/2023
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Removed prescriber criteria.</li> <li>2. Removed age criteria.</li> <li>3. Removed dosing criteria.</li> <li>4. Updated continuation of therapy language.</li> <li>5. Removed reauthorization requirement for positive response to therapy</li> <li>6. Updated approval duration verbiage.</li> </ol>	03/21/2025	04/10/2025
<p>Policy reviewed.</p>	12/11/2025	12/11/2025

