

Clinical Policy Title:	revumenib
Policy Number:	RxA.nnn
Drug(s) Applied:	Revuforj
Original Policy Date:	6/19/2025
Last Review Date:	3/25/2026
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Acute Leukemia (must meet all):

1. Diagnosis of relapsed or refractory acute leukemia;
2. Documentation of KMT2A gene translocation.

Approval duration

All Lines of Business (except Medicare): 12 months

B. Acute Myeloid Leukemia (must meet all):

1. Diagnosis of relapsed or refractory acute myeloid leukemia;
2. Documentation of susceptible NPM1 mutation

Approval duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. Indication (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. NCCN Clinical Practice Guidelines in Oncology™. © 2022 National Comprehensive Cancer Network, Inc. For additional information visit the NCCN website: <http://www.nccn.org/index.asp>
2. NCCN Guidelines Acute Lymphoblastic Leukemia https://www.nccn.org/professionals/physician_gls/pdf/all.pdf
3. NCCN Guidelines Acute Myeloid Leukemia https://www.nccn.org/professionals/physician_gls/pdf/aml.pdf
4. Package insert: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/218944s000lbl.pdf
5. Syndax announces FDA approval of Revuforj (revumenib), the first and only menin inhibitor to treat adult and pediatric patients with relapsed or refractory acute leukemia with a KMT2A translocation. News release. Syndax Pharmaceuticals; November 15, 2024 <https://ir.syndax.com/news-releases/news-release-details/syndax-announces-fda-approval-revuforjr-revumenib-first-and-only>
6. Revuforj Package Insert. [Revuforj-full-prescribing-info.pdf](#)

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.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	6/19/2025	6/19/2025
Policy reviewed 1. New FDA approved diagnosis added, acute myeloid Leukemia	12/1/2025	12/11/2025
Policy was reviewed 1. Removed patient has no satisfactory alternative treatment and used as monotherapy criteria from acute myeloid leukemia diagnosis	03/25/2026	03/26/2026