Utilization Review Policy 264

POLICY: Oncology (Injectable) **–** Vyxeos Utilization Management Medical Policy

- Vyxeos® (daunorubicin and cytarabine liposome for injection – Jazz Pharmaceuticals)

EFFECTIVE DATE: 1/1/2022
REVIEW DATE: 12/17/2025

COVERAGE CRITERIA FOR: All Aspirus Medicare Plans

OVERVIEW

Vyxeos is a liposomal combination of daunorubicin, an anthracycline topoisomerase inhibitor, and cytarabine, a nucleoside metabolic inhibitor. It is indicated for the treatment of newly-diagnosed therapy-related **acute myeloid leukemia** (AML) or **AML with myelodysplasia-related changes** in patients ≥ 1 year of age.[1]

Dosing Information

Vyxeos is supplied in single-dose vials containing 44 mg daunorubicin and 100 mg cytarabine.[1] The recommended induction cycle dose is one vial/m^2 (daunorubicin 44 mg/m^2 and cytarabine 100 mg/m^2) administered intravenously on Days 1, 3, and 5. A second course of induction therapy (one vial/m^2) can be administered 2 to 5 weeks after the first induction cycle in patients who do not achieve remission with the first course. The second cycle of induction therapy is administered intravenously on Days 1 and 3. Consolidation therapy can begin 5 to 8 weeks after induction and the dose is 0.65 vials/m^2 (daunorubicin 29 mg/m^2 and cytarabine 65 mg/m^2) administered intravenously on Days 1 and 3. A second course of consolidation therapy (0.65 vials/m^2) can be given 5 to 8 weeks after the first cycle of consolidation therapy.

Guidelines

The National Comprehensive Cancer Network guidelines for **acute myeloid leukemia** (version 3.2026 – November 24, 2025) recommend Vyxeos for induction and post-remission therapy for patients with therapy-related AML, antecedent myelodysplastic syndrome/chronic myelomonocytic leukemia, and AML with myelodysplasia-related changes.[2,3]

POLICY STATEMENT

Prior Authorization is recommended for medical benefit coverage of Vyxeos. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indication. Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required

for evaluation and diagnosis of patients treated with Vyxeos as well as the monitoring required for adverse events and long-term efficacy, approval requires Vyxeos to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Vyxeos is recommended in those who meet the following criteria:

FDA-Approved Indication

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1. **Acute Myeloid Leukemia.** Approve for 6 months if the patient meets ALL of the following (A, B, and C):
   - **A)** Patient is ≥ 1 year of age; AND
   - **B)** Patient meets ONE of the following (i, ii, iii or iv):
     - **i.** Patient has therapy-related acute myeloid leukemia; OR
     - **ii.** Patient has antecedent myelodysplastic syndrome/chronic myelomonocytic leukemia; OR
     - **iii.** Patient has poor-risk acute myeloid leukemia; OR
     - **iv.** Patient has cytogenetic or molecular changes consistent with myelodysplastic syndrome (previously classified as acute myeloid leukemia with myelodysplasia-related changes); AND
   - **C)** The medication is prescribed by or in consultation with an oncologist.

   Dosing. Approve the following dosing regimens (A and B):
   - **A)** Induction: Each individual dose must not exceed one vial/m^2 (daunorubicin 44 mg/m^2 and cytarabine 100 mg/m^2) administered intravenously up to three times in each cycle; AND
   - **B)** Consolidation: Each individual dose must not exceed 0.65 vials/m^2 (daunorubicin 29 mg/m^2 and cytarabine 65 mg/m^2) administered intravenously up to two times in each cycle.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Vyxeos is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Vyxeos liposome intravenous infusion [prescribing information]. Palo Alto, CA: Jazz Pharmaceuticals; September 2022.
2. The NCCN Drugs & Biologics Compendium. © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on December 10, 2025. Search term: Vyxeos.
3. The NCCN Acute Myeloid Leukemia Clinical Practice Guidelines in Oncology (version 3.2026 – November 24, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on December 10, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	11/30/2022
Annual Revision	No criteria changes.	12/13/2023
Aspirus P&T Review	Policy reviewed and approved by Aspirus P&T committee. Annual review process	09/16/2024
Annual Revision	No criteria changes.	12/18/2024
Aspirus P&T Review	Policy reviewed and approved by Aspirus P&T committee. Annual review process	09/15/2025
Annual Revision	**Acute Myeloid Leukemia:** The option for approval that patient has secondary acute myeloid leukemia was removed. Poor-risk acute myeloid leukemia and cytogenetic or molecular changes consistent with myelodysplastic syndrome were added as options for approval.	12/17/2025