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| <b>Clinical Policy Title:</b>              | temozolomide                            |
| <b>Policy Number:</b>                      | RxA.872                                 |
| <b>Drug(s) Applied:</b>                    | temozolomide                            |
| <b>Original Policy Date:</b>               | 10/11/2024                              |
| <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. Anaplastic astrocytoma (must meet all):

1. Diagnosis of one of the following (a or b):
  - a. Newly diagnosed anaplastic astrocytoma of brain as adjuvant;
  - b. Refractory anaplastic astrocytoma of brain.

**Approval duration**

**All Lines of Business (except Medicare):** 12 months

#### B. Glioblastoma (must meet all):

1. Diagnosis of newly diagnosed glioblastoma;
2. Prescribed concomitantly with radiotherapy and then as maintenance.

**Approval duration**

**All Lines of Business (except Medicare):** 12 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. Temodar. Prescribing Information. Whitehouse Station, NJ: Merck Sharp & Dohme LLC; September 2023. Available at: [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2023/022277s017\\_018\\_019lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/022277s017_018_019lbl.pdf). Accessed October 11, 2024.

| Review/Revision History   | Review/Revision Date | P&T Approval Date |
|---|----------------------|-------------------|
| Policy established.   | 10/11/2024           | 12/05/2024        |
| Policy was reviewed:<br>1. Removed Temodar from drug applied section. | 12/05/2024           | N/A               |
| Policy reviewed   | 12/11/2025           | 12/11/2025        |

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.

