CARECONTINUUM™

UTILIZATION MANAGEMENT MEDICAL POLICY

POLICY: Oncology (Injectable – Histone Deacetylase Inhibitor) – Romidepsin Products Utilization Management Medical Policy
- Istodax® (romidepsin intravenous infusion – Celgene, generic)

REVIEW DATE: 06/24/2026

OVERVIEW

Romidepsin, a histone deacetylase inhibitor, is indicated for the treatment of **cutaneous T-cell lymphoma** in patients who have received at least one prior systemic therapy.[1]

Guidelines

Romidepsin is addressed in National Comprehensive Cancer Network (NCCN) guidelines:

- **Primary Cutaneous Lymphomas:** Guidelines (version 2.2026 – February 13, 2026) recommend romidepsin as systemic therapy for mycosis fungoides/Sezary syndrome with or without skin-directed therapy and as a single agent for relapsed or refractory primary cutaneous CD30+ T-cell lymphoproliferative disorders.[2,3] In addition, NCCN recommends therapy for subcutaneous Panniculitis-Like T-Cell lymphoma with hemophagocytic lymphohistiocytosis, systemic disease or high tumor burden. NCCN also recommends therapy for subcutaneous Panniculitis-Like T-Cell lymphoma without hemophagocytic lymphohistiocytosis and with low tumor burden (category 2A).
- **T-Cell Lymphomas:** Guidelines (version 2.2026 – February 13, 2026) recommend romidepsin as a single agent for the second-line or subsequent therapy of relapsed or refractory peripheral T-cell lymphomas including anaplastic large cell lymphoma; peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, and nodal peripheral T-cell lymphoma with T-follicular helper (TFH) phenotype; follicular T-cell lymphoma; breast implant-associated anaplastic large cell lymphoma; extranodal NK/T-cell lymphoma; and hepatosplenic T-cell lymphoma.[3,4]

POLICY STATEMENT

Prior Authorization is recommended for medical benefit coverage of romidepsin. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indications. 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. Because of the specialized skills required for evaluation and diagnosis of patients treated with romidepsin as well as the monitoring required for adverse events and long-term efficacy, approval requires romidepsin to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

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

FDA-Approved Indications

1. **Cutaneous CD30+ T-Cell Lymphoproliferative Disorders.** Approve for 1 year if the patient meets ALL of the following (A, B, C, D, and E):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has relapsed or refractory disease; AND
   C) Patient has ONE of the following diagnoses (i or ii):
      i. Primary cutaneous anaplastic large cell lymphoma with multifocal lesions; OR
      ii. Cutaneous anaplastic large cell lymphoma with regional nodes; AND
      Note: This excludes systemic anaplastic large cell lymphoma, which is reviewed under the "T-cell lymphoma" criteria.
   D) The medication is used as a single agent; AND
   E) The medication is prescribed by or in consultation with an oncologist.

   Dosing. Approve up to 14 mg/m^2 administered intravenously on Days 1, 8, and 15 of each 28-day cycle.

2. **Mycosis Fungoides/Sezary Syndrome.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) The medication is prescribed by or in consultation with an oncologist or dermatologist.

   Dosing. Approve up to 14 mg/m^2 administered intravenously on Days 1, 8, and 15 of each 28-day cycle.

Other Uses with Supportive Evidence

3. **Breast Implant-Associated Anaplastic Large Cell Lymphoma.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has relapsed or refractory disease; AND
   C) The medication is prescribed by or in consultation with an oncologist.

   Dosing. Approve up to 14 mg/m^2 administered intravenously on Days 1, 8, and 15 of each 28-day cycle.

4. **Extranodal NK/T-Cell Lymphoma.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has relapsed/refractory disease; AND
   C) The medication is used as a single agent; AND
   D) The medication is prescribed by or in consultation with an oncologist.

   Dosing. Approve up to 14 mg/m^2 administered intravenously on Days 1, 8, and 15 of each 28-day cycle.

5. **Hepatosplenic T-Cell Lymphoma.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   A) Patient is ≥ 18 years of age; AND
   B) The medication is used as subsequent therapy after two systemic regimens; AND
   Note: Examples of primary treatment regimens include ICE (ifosfamide, carboplatin, etoposide), DHAP (dexamethasone, cytarabine, cisplatin), DHAX (dexamethasone, cytarabine, oxaliplatin), IVAC (ifosfamide, etoposide, cytarabine).
   C) The medication is prescribed by or in consultation with an oncologist.

   Dosing. Approve up to 14 mg/m^2 administered intravenously on Days 1, 8, and 15 of each 28-day cycle.

6. **Subcutaneous Panniculitis-Like T-Cell Lymphoma.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   A) Patient is ≥ 18 years of age; AND
   B) Patient meets ONE of the following (i or ii):
      i. Patient has hemophagocytic lymphohistiocytosis, systemic disease or high tumor burden; OR
      ii. Patient meets BOTH of the following (a and b):
         a) Patient has low tumor burden without hemophagocytic lymphohistiocytosis; AND
         b) Medication is used as subsequent therapy; AND
   C) The medication is prescribed by or in consultation with an oncologist.

   Dosing. Approve up to 14 mg/m^2 administered intravenously on Days 1, 8, and 15 of each 28-day cycle.

7. **T-Cell Lymphoma.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   Note: Examples of peripheral T-cell lymphoma include anaplastic large cell lymphoma, enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, angioimmunoblastic T-cell lymphoma, peripheral T-cell lymphoma not otherwise specified, nodal peripheral T-cell lymphoma and follicular T-cell lymphoma.
   A) Patient is ≥ 18 years of age; AND
   B) Patient has relapsed, refractory, or progressive disease; AND
   C) The medication is prescribed by or in consultation with an oncologist.

   Dosing. Approve up to 14 mg/m^2 administered intravenously on Days 1, 8, and 15 of each 28-day cycle.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of romidepsin 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. Istodax® intravenous infusion [prescribing information]. Bridgewater, NJ: Amneal; September 2025.
2. The NCCN Primary Cutaneous Lymphomas Clinical Practice Guidelines in Oncology (version 2.2026 – February 13, 2026). © 2026 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on June 17, 2026.
3. The NCCN Drugs and Biologics Compendium. © 2026 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on June 17, 2026. Search term: romidepsin.
4. The NCCN T-Cell Lymphomas Clinical Practice Guidelines in Oncology (version 2.2026 – February 13, 2026). ©2026 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on June 17, 2026.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	06/12/2024
Update	04/08/2025: The policy name was changed from "Oncology (Injectable) – Romidepsin Products UM Medical Policy" to "Oncology (Injectable – Histone Deacetylase Inhibitor) – Romidepsin Products UM Medical Policy".	N/A
Annual Revision	**Breast Implant-Associated Anaplastic Large Cell Lymphoma:** Removed the requirement that romidepsin is used as a single agent. **Extranodal NK/T-Cell Lymphoma:** Removed the requirement following combination asparaginase-based chemotherapy. **Hepatosplenic T-Cell Lymphoma:** Removed 'primary treatment" as a requirement and added "systemic" as an option for approval. Removed the requirement that romidepsin is used as a single agent. **Subcutaneous Panniculitis-Like T-Cell Lymphoma:** Added new condition for approval and criteria. **T-Cell Lymphoma:** Removed the requirements that patient has relapsed or refractory disease and romidepsin is used as a single agent.	06/18/2025
Annual Revision	**Cutaneous CD30+ T-Cell Lymphoproliferate Disorders:** A Note was added to the requirement that the patient has primary cutaneous anaplastic large cell lymphoma with multifocal lesions or cutaneous anaplastic large cell lymphoma with regional nodes, to clarify that this excludes systemic anaplastic large cell lymphoma, which is reviewed under T-Cell Lymphoma. **T-Cell Lymphoma**: The Note of examples was updated to include nodal peripheral T-cell lymphoma and follicular T-cell lymphoma. The requirement for peripheral disease was changed to require relapsed, refractory, or progressive disease.	06/24/2026