CARECONTINUUM™

UTILIZATION MANAGEMENT MEDICAL POLICY

POLICY: Oncology (Injectable – Antibody-Drug Conjugate – CD123) – Decnupaz Utilization Management Medical Policy
- Decnupaz™ (pivekimab sunirine-pvzy intravenous infusion – AbbVie)

REVIEW DATE: 06/03/2026

OVERVIEW

Decnupaz, a CD123-directed antibody and alkylating agent conjugate, is indicated for the treatment of **blastic plasmacytoid dendritic cell neoplasm** (BPDCN) in adults.[1]

Dosing Information

The recommended dose of Decnupaz in adult patients with BPDCN is 0.045 mg/kg administered intravenously over approximately 15 to 30 minutes once every 3 weeks (21-day cycle) until disease progression or unacceptable toxicity.[1] Dose should be based on patient actual body weight.

Guidelines

Decnupaz is not addressed in the National Comprehensive Cancer Network clinical practice guidelines for **Acute Myeloid Leukemia** (version 3.2026 – November 24, 2025).[2] The guidelines recommend Elzonris® (tagraxofusp-erzs intravenous injection) for the treatment of BPDCN in patients ≥ 18 years of age.[2] Elzonris is recommended for both treatment induction and for relapsed/refractory disease (if not already used) [category 2A recommendation in both settings].

POLICY STATEMENT

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

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

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

FDA-Approved Indication

1. **Blastic Plasmacytoid Dendritic Cell Neoplasm.** 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 consultation with an oncologist or hematologist.

Dosing. Approve up to 0.045 mg/kg administered intravenously once every 3 weeks (21-day cycle).

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Decnupaz 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. Decnupaz™ [prescribing information]. North Chicago, IL: AbbVie; May 2026.
2. 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 May 27, 2026.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	06/03/2026