

UTILIZATION MANAGEMENT MEDICAL POLICY

POLICY: Oncology (Injectable) – Decitabine Products Utilization Management Medical Policy

- Dacogen® (decitabine intravenous infusion – Otsuka, generic)

REVIEW DATE: 12/17/2025

OVERVIEW

Decitabine (Dacogen), a hypomethylating agent, is indicated for the treatment of **myelodysplastic syndromes** (MDS) in adults including previously treated and untreated, *de novo* and secondary MDS of all French-American-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, refractory anemia with excess blasts in transformation, and chronic myelomonocytic leukemia) and intermediate-1, intermediate-2, and high-risk International Prognostic Scoring System groups.¹

Guidelines

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

- **Acute Myeloid Leukemia:** Guidelines (version 3.2026 – November 24, 2025) recommend decitabine as a single agent, or in combination with Nexavar® (sorafenib tablet) or Venclexta® (venetoclax tablet) for lower intensity therapy, consolidation therapy, and for the treatment of relapsed/refractory disease.^{2,4} Decitabine in combination with Venclexta is also recommended for intensive induction therapy. In addition, decitabine is recommended in combination with Venclexta for relapsed/refractory blastic plasmacytoid dendritic cell neoplasm.
- **Myelodysplastic Syndromes:** Guidelines (version 1.2026 – October 9, 2025) recommend decitabine for the treatment of lower risk and higher risk MDS, and for the treatment of myelodysplastic/myeloproliferative neoplasms.^{2,3}
- **Myeloproliferative Neoplasms:** Guidelines (version 2.2025 – July 8, 2025) recommend decitabine for the treatment of myeloproliferative neoplasms (MPN)-accelerated phase or MPN-blast/acute myeloid leukemia phase.^{2,5}
- **Hodgkin Lymphoma:** Guidelines (version 1.2026 – October 22, 2025) recommend decitabine for the treatment of disease refractory to at least 3 prior lines of subsequent therapy in combination with pembrolizumab (category 2A).^{2,12}

POLICY STATEMENT

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

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

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

FDA-Approved Indication

1. **Myelodysplastic Syndromes.** Approve for 1 year if the patient meets BOTH of the following (A and B):

Note: Examples include refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, refractory anemia with excess blasts in transformation, and chronic myelomonocytic leukemia.

- A) Patient is ≥ 18 years of age; AND
- B) The medication is prescribed by or in consultation with an oncologist.

Dosing. Approve ONE of the following dosing regimens (A or B):

- A) Each individual dose must not exceed 15 mg/m^2 administered by intravenous infusion up to 3 times daily for up to 3 days in each 42-day cycle; OR
- B) Each individual dose must not exceed 20 mg/m^2 administered by intravenous infusion once daily for up to 5 days in each 28-day cycle.

Other Uses with Supportive Evidence

2. **Acute Myeloid Leukemia.** 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.

Dosing. Each individual dose must not exceed 20 mg/m^2 administered by intravenous infusion once daily for up to 10 days of each 28-day cycle.

3. **Blastic Plasmacytoid Dendritic Cell Neoplasm.** 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 in combination with Venclexta (venetoclax tablets); AND
 - C) The medication is prescribed by or in consultation with an oncologist.

Dosing. Approve ONE of the following dosing regimens (A or B):

- A) Each individual dose must not exceed 15 mg/m^2 administered by intravenous infusion up to 3 times daily for up to 3 days in each 42-day cycle; OR
- B) Each individual dose must not exceed 20 mg/m^2 administered by intravenous infusion once daily for up to 5 days in each 28-day cycle.

4. **Hodgkin 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 tried at least three prior regimens; AND
 - C) The medication is used in combination with Keytruda (pembrolizumab intravenous infusion); AND
 - D) The medication is prescribed by or in consultation with an oncologist.
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Dosing. Dose must not exceed 10 mg/day administered by intravenous infusion once daily for up to 5 days in each 21-day cycle.

5. Myeloproliferative Neoplasms. 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 accelerated phase; OR
 - ii. Patient has blast/acute myeloid leukemia phase; AND
- C) The medication is prescribed by or in consultation with an oncologist.

Dosing. Each individual dose must not exceed 20 mg/m² administered by intravenous infusion once daily for up to 5 days in each 28-day cycle.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of decitabine 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

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12. The NCCN Hodgkin Lymphoma Clinical Practice Guidelines in Oncology (version 1.2026 – October 22, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on December 11, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	Acute Myeloid Leukemia: Removed requirement that the patient is ≥ 60 years of age, has relapsed or refractory disease, OR has unfavorable cytogenetics and TP53 mutation.	12/13/2023
Annual Revision	Myeloproliferative Neoplasms: Name changed from Myelofibrosis to Myeloproliferative Neoplasms.	12/11/2024
Annual Revision	Blastic Plasmacytoid Dendritic Cell Neoplasm: The requirements that patient has relapsed or refractory disease and decitabine is used for palliative treatment were removed. Hodgkin Lymphoma: Hodgkin lymphoma was added as a new condition of approval under “Other Uses with Supportive Evidence”.	12/17/2025