

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1477-1
Program	Prior Authorization/Notification
Medication	Romvimza™ (vimseltinib)
P&T Approval Date	4/2025
Effective Date	7/1/2025

1. Background:

Romvimza is a kinase inhibitor indicated for treatment of adult patients with symptomatic tenosynovial giant cell tumor (TGCT) for which surgical resection will potentially cause worsening functional limitation or severe morbidity.

Coverage Information:

Members will be required to meet the criteria below for coverage. For members under the age of 19 years, the prescription will automatically process without a coverage review.

Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances. Some states also mandate usage of other Compendium references. Where such mandates apply, they supersede language in the benefit document or in the notification criteria.

2. Coverage Criteria^a:

<p>A. <u>Patients less than 19 years of age</u></p> <p>1. Romvimza will be approved based on the following criterion:</p> <p style="padding-left: 40px;">a. Patient is less than 19 years of age</p> <p style="text-align: center;">Authorization will be issued for 12 months.</p> <p>B. Tenosynovial Giant Cell Tumor (TGCT)</p> <p>1. <u>Initial Authorization</u></p> <p style="padding-left: 40px;">a. Romvimza will be approved based on <u>both</u> of the following criteria:</p> <p style="padding-left: 80px;">(1) Diagnosis of tenosynovial giant cell tumor (TGCT)</p> <p style="text-align: center;">-AND-</p> <p style="padding-left: 80px;">(2) Surgical resection will potentially cause worsening functional limitation or severe morbidity</p> <p style="text-align: center;">Authorization will be issued for 12 months.</p> <p>2. <u>Reauthorization</u></p>
--

<p>a. Romvimza will be approved based on the following criterion:</p> <p>(1) Patient does not show evidence of progressive disease while on Romvimza therapy</p> <p>Authorization will be issued for 12 months.</p> <p>C. <u>NCCN Recommended Regimens</u></p> <p>The drug has been recognized for treatment of the cancer indication by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.</p> <p>Authorization will be issued for 12 months.</p> <p>^a State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.</p>

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

- Romvimza [package insert]. Waltham, MA: Deciphera Pharmaceuticals, LLC; February, 2025.

Program	Program type - Prior Authorization/Notification – Romvimza (vimseltinib)
Change Control	
4/2025	New program.