

**Generic Name:** ziftomenib

**Therapeutic Class or Brand Name:** Komzifti

**Applicable Drugs:** N/A

**Preferred:** N/A

**Non-preferred:** N/A

**Date of Origin:** 6/1/2026

**Date Last Reviewed / Revised:** N/A

## PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I to V are met.)

- I. Documentation of the following FDA-approved diagnosis and must meet all criteria listed under the applicable diagnosis:  
FDA-Approved Indication(s)
  - A. Acute Myeloid Leukemia
    - i. Documentation of nucleophosmin 1 (NPM1) mutation
    - ii. Documentation of relapsed or refractory disease
    - iii. Documentation or attestation by physician that there are no satisfactory alternative treatment options.
- II. Minimum age requirement: 18 years old or older.
- III. Treatment must be prescribed by or in consultation with an oncologist or hematologist.
- IV. Request is for a medication with the appropriate FDA labeling, or its use is supported by current National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1 or 2A.
- V. Refer to the plan document for the list of preferred products. If the requested agent is not listed as a preferred product, must have documented treatment failure or contraindication to the preferred product(s).

## EXCLUSION CRITERIA

- N/A

## OTHER CRITERIA

- N/A

## QUANTITY / DAYS SUPPLY RESTRICTIONS

- Quantity limited to #90 capsules per 30 days

## APPROVAL LENGTH

- **Authorization:** 6 months
- **Re-Authorization:** 6 months. An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and does not show evidence of progressive disease.

## APPENDIX

N/A

## REFERENCES

1. Komzifti. Prescribing Information. Kura Oncology, Inc. 2025. Accessed March 5, 2026. [www.accessdata.fda.gov/drugsatfda\\_docs/label/2025/220305s000lbl.pdf](http://www.accessdata.fda.gov/drugsatfda_docs/label/2025/220305s000lbl.pdf)
2. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Acute Myeloid Leukemia. Version 3.2026. Updated November 24, 2025. Accessed March 6, 2026. [www.nccn.org/professionals/physician\\_gls\\_pdf/aml.pdf](http://www.nccn.org/professionals/physician_gls_pdf/aml.pdf)

**DISCLAIMER:** Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.