This Coverage Policy applies to Individual Health Insurance Marketplace benefit plans only.

**Dacogen® (decitabine)**

**COVERAGE POLICY**

Dacogen is covered for members who meet the following criteria:

A. Acute myeloid leukemia (AML), OR
B. Myelodysplastic syndrome (MDS).

**AUTHORIZATION PERIOD AND LIMITATIONS**

*Initial Approval:* 6 months

**NON-COVERAGE**

Dacogen is NOT covered for members with the following criteria:

A. Use not approved by the FDA; and
B. The use is unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining ‘accepted use’)

**REFERENCES**