

# Drug Policy

<b>Policy:</b>	<b>Oncology Care Value Preferred Specialty Management</b>	<b>Annual Review Date:</b> <b>11/21/2024</b>
<b>Impacted Drugs:</b>	<b>Bosulif</b> <b>Braftovi</b> <b>Ibrance</b> <b>Iclusig</b> <b>Lupron Depot 7.5 mg, 22.5 mg, 30 mg, 45 mg</b> <b>Mektovi</b> <b>Orgovyx</b> <b>Scemblix</b> <b>Tasigna</b>	<b>Last Revised Date:</b> <b>11/21/2024</b>

**OVERVIEW**

This Care Value policy involves the use of antineoplastic agents used in the treatment and management of oncologic conditions. This policy does **not** include the requirement of a generic trial for multi-source brand (MSB) oncology agents.

**POLICY STATEMENT**

This Preferred Specialty Management program has been developed to encourage the use of a Preferred Product prior to a Non-Preferred Product. For all medications (Preferred and Non-Preferred), the patient is required to meet the respective standard *Prior Authorization Policy* criteria and to try the Preferred Products prior to the approval of a Non-Preferred Product. Requests for the Non-Preferred Product will be reviewed using the exception criteria (below). If the patient meets the standard *Prior Authorization Policy* criteria for the Non-Preferred Product, but has not tried the Preferred Products, a review will be offered for the Preferred Products using the respective standard *Prior Authorization Policy* criteria. All approvals are provided for the duration noted below.

**Automation:** None.

**Melanoma**

**BRAF Inhibitors:**

- |                              |                    |
|------------------------------|--------------------|
| <b>Preferred Products</b>    | Zelboraf, Tafinlar |
| <b>Non-Preferred Product</b> | Braftovi           |

**MEK Inhibitors:**

- |                              |                    |
|------------------------------|--------------------|
| <b>Preferred Products</b>    | Cotellic, Mekinist |
| <b>Non-Preferred Product</b> | Mektovi            |

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## Non-Small Cell Lung Cancer (NSCLC)

### **BRAF Inhibitors:**

<b>Preferred Product</b>	Tafinlar
<b>Non-Preferred Product</b>	Braftovi

### **MEK Inhibitors:**

<b>Preferred Product</b>	Mekinist
<b>Non-Preferred Product</b>	Mektovi

## Prostate Cancer

<b>Preferred Product</b>	Eligard
<b>Non-Preferred Product</b>	Orgovyx, Lupron Depot (7.5 mg, 22.5 mg, 30 mg, 45 mg only)

## Breast Cancer

<b>Preferred Products</b>	Verzenio, Kisqali, Kisqali Femara Co-Pack
<b>Non-Preferred Product</b>	Ibrance

## Chronic Myeloid Leukemia (CML)

<b>Preferred Products</b>	generic imatinib, generic dasatinib
<b>Non-Preferred Products</b>	Bosulif, Tasigna, Iclusig, Scemblix

## RECOMMENDED EXCEPTION CRITERIA

<b>Non-Preferred Product</b>	<b>Exception Criteria</b>
<b>Braftovi</b>	<p><b>1. Melanoma, BRAF V600 Mutation-Positive Disease:</b> Approve for 1 year if the patient meets ONE of the following (A <u>or</u> B):</p> <p><b>A)</b> Patient meets BOTH of the following:</p> <ul style="list-style-type: none"> <li><b>i.</b> Patient meets the standard <i>Braftovi Prior Authorization Policy (General Oncology)</i> criteria; AND</li> <li><b>ii.</b> Patient meets ONE of the following (a <u>or</u> b): <ul style="list-style-type: none"> <li><b>a)</b> Patient has tried one of Zelboraf or Tafinlar; OR</li> <li><b>b)</b> Patient is currently receiving Braftovi; OR</li> </ul> </li> </ul> <p><b>B)</b> If the patient has met the standard <i>Braftovi Prior Authorization Policy (General Oncology)</i> criteria, but has not met the exception criteria above (Aii), offer to review for one of the Preferred Products using either the standard <i>Zelboraf Prior Authorization Policy (General Oncology)</i> criteria <u>or</u> the <i>Tafinlar Prior Authorization Policy (General Oncology)</i> criteria.</p>

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Non-Preferred Product	Exception Criteria
	<p><b>2. Non-Small Cell Lung Cancer, BRAF V600E Mutation-Positive Disease:</b> Approve for 1 year if the patient meets ONE of the following (A <u>or</u> B):</p> <p><b>A)</b> Patient meets BOTH of the following:</p> <ul style="list-style-type: none"> <li><b>i.</b> Patient meets the standard <i>Braftovi Prior Authorization Policy (General Oncology)</i> criteria; AND</li> <li><b>ii.</b> Patient meets ONE of the following (a <u>or</u> b): <ul style="list-style-type: none"> <li><b>a)</b> Patient has tried Tafinlar; OR</li> <li><b>b)</b> Patient is currently receiving Braftovi; OR</li> </ul> </li> </ul> <p><b>B)</b> If the patient has met the standard <i>Braftovi Prior Authorization Policy (General Oncology)</i> criteria, but has not met the exception criteria above (Aii), offer to review for the Preferred Product using the standard <i>Tafinlar Prior Authorization Policy (General Oncology)</i> criteria.</p> <p><b>3. Other Conditions:</b> Approve for 1 year if the patient meets the standard <i>Braftovi Prior Authorization Policy (General Oncology)</i> criteria.</p>
Mektovi	<p><b>1. Melanoma, BRAF V600 Mutation-Positive Disease:</b> Approve for 1 year if the patient meets ONE of the following (A <u>or</u> B):</p> <p><b>A)</b> Patient meets BOTH of the following:</p> <ul style="list-style-type: none"> <li><b>i.</b> Patient meets the standard <i>Mektovi Prior Authorization Policy (General Oncology)</i> criteria; AND</li> <li><b>ii.</b> Patient meets ONE of the following (a <u>or</u> b): <ul style="list-style-type: none"> <li><b>a)</b> Patient has tried one of Cotellic or Mekinist; OR</li> <li><b>b)</b> Patient is currently receiving Mektovi; OR</li> </ul> </li> </ul> <p><b>B)</b> If the patient has met the standard <i>Mektovi Prior Authorization Policy (General Oncology)</i> criteria, but has not met the exception criteria above (Aii), offer to review for one of the Preferred Products using either the standard <i>Cotellic Prior Authorization Policy (General Oncology)</i> criteria <u>or</u> the <i>Mekinist Prior Authorization Policy (General Oncology)</i> criteria.</p> <p><b>2. Non-Small Cell Lung Cancer, BRAF V600E Mutation-Positive Disease:</b> Approve for 1 year if the patient meets ONE of the following (A <u>or</u> B):</p> <p><b>A)</b> Patient meets BOTH of the following:</p> <ul style="list-style-type: none"> <li><b>i.</b> Patient meets the standard <i>Mektovi Prior Authorization Policy (General Oncology)</i> criteria; AND</li> <li><b>ii.</b> Patient meets ONE of the following (a <u>or</u> b): <ul style="list-style-type: none"> <li><b>a)</b> Patient has tried Mekinist; OR</li> <li><b>b)</b> Patient is currently receiving Mektovi; OR</li> </ul> </li> </ul> <p><b>B)</b> If the patient has met the standard <i>Mektovi Prior Authorization Policy (General Oncology)</i> criteria, but has not met the exception criteria above (Aii), offer to review for the Preferred Product using the standard <i>Mekinist Prior Authorization Policy (General Oncology)</i> criteria.</p> <p><b>3. Other Conditions:</b> Approve for 1 year if the patient meets the standard <i>Mektovi Prior Authorization Policy (General Oncology)</i> criteria.</p>
Lupron Depot (7.5 mg, 22.5	<p><b>1. Prostate Cancer, Advanced:</b> Approve for 1 year if the patient meets ONE of the following (A <u>or</u> B):</p>

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Non-Preferred Product	Exception Criteria
<b>mg, 30 mg, 45 mg only)</b>	<p>A) Patient meets BOTH of the following:</p> <ul style="list-style-type: none"> <li>i. Patient meets the standard <i>Lupron Depot Prior Authorization Policy (Gonadotropin-Releasing Hormone Agonists- Injectable Long-Acting Products)</i> criteria; AND</li> <li>ii. Patient meets ONE of the following (a <u>or</u> b):               <ul style="list-style-type: none"> <li>a) Patient has tried Eligard; OR</li> <li>b) Patient is currently receiving Lupron Depot 7.5 mg, 22.5 mg, 30 mg or 45 mg; OR</li> </ul> </li> </ul> <p>B) If the patient has met the standard <i>Lupron Depot Prior Authorization Policy (Gonadotropin-Releasing Hormone Agonists- Injectable Long-Acting Products)</i> criteria, but has not met the exception criteria above (Aii), offer to review for the Preferred Product using the standard <i>Eligard Prior Authorization Policy (General Oncology)</i> criteria.</p> <p>2. <b>Other Conditions:</b> Approve for 1 year if the patient meets the standard <i>Lupron Depot Prior Authorization Policy (Gonadotropin-Releasing Hormone Agonists- Injectable Long-Acting Products)</i> criteria.</p>
<b>Orgovyx</b>	<p>1. <b>Prostate Cancer, Advanced:</b> Approve for 1 year if the patient meets ONE of the following (A <u>or</u> B):</p> <p>A) Patient meets BOTH of the following:</p> <ul style="list-style-type: none"> <li>i. Patient meets the standard <i>Orgovyx Prior Authorization Policy (General Oncology)</i> criteria; AND</li> <li>ii. Patient meets ONE of the following (a <u>or</u> b):               <ul style="list-style-type: none"> <li>a) Patient has tried Eligard; OR</li> <li>b) Patient is currently receiving Orgovyx; OR</li> </ul> </li> </ul> <p>B) If the patient has met the standard <i>Orgovyx Prior Authorization Policy (General Oncology)</i> criteria, but has not met the exception criteria above (Aii), offer to review for the Preferred Product using the standard <i>Eligard Prior Authorization Policy (General Oncology)</i> criteria.</p> <p>2. <b>Other Conditions:</b> Approve for 1 year if the patient meets the standard <i>Orgovyx Prior Authorization Policy (General Oncology)</i> criteria.</p>
<b>Ibrance</b>	<p>1. <b>Breast Cancer.</b> Approve for 1 year if the patient meets the following (A <u>or</u> B):</p> <p>A) Patient meets both of the following (i <u>and</u> ii):</p> <ul style="list-style-type: none"> <li>i. Patient meets the standard <i>Ibrance Prior Authorization Policy (General Oncology)</i> criteria; AND</li> <li>ii. Patient meets ONE of the following (a <u>or</u> b):               <ul style="list-style-type: none"> <li>a) Patient has been taking Ibrance and is continuing therapy; OR</li> <li>b) Patient has tried one of Kisqali, Kisqali Femara Co-Pack, or Verzenio; OR</li> </ul> </li> </ul> <p>B) If the patient has met the standard <i>Ibrance Prior Authorization Policy (General Oncology)</i> criteria, but has not met the exception criteria (Aii), offer to review for one of the Preferred Products using either the standard <i>Kisqali and Kisqali Femara Co-Pack Prior Authorization Policy (General Oncology)</i> criteria <u>or</u> the <i>Verzenio Prior Authorization Policy (General Oncology)</i> criteria.</p> <p>2. <b>Other Conditions.</b> Approve for 1 year if the patient meets the standard <i>Ibrance Prior Authorization Policy (General Oncology)</i> criteria.</p>

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Non-Preferred Product	Exception Criteria
<b>Bosulif</b>	<p><b>1. Philadelphia chromosome-positive Chronic Myeloid Leukemia (Ph+ CML).</b> Approve for 1 year if the patient meets the following (A <u>or</u> B):</p> <p><b>A)</b> Patient meets both of the following (i <u>and</u> ii):</p> <ul style="list-style-type: none"> <li><b>i.</b> Patient meets the standard <i>Bosulif Prior Authorization Policy (General Oncology)</i> criteria; AND</li> <li><b>ii.</b> Patient meets ONE of the following (a <u>or</u> b):           <ul style="list-style-type: none"> <li><b>a)</b> Patient has tried BOTH generic imatinib AND generic dasatinib; OR</li> <li><b>b)</b> Patient is currently receiving Bosulif; OR</li> </ul> </li> </ul> <p><b>B)</b> If the patient has met the standard <i>Bosulif Prior Authorization Policy (General Oncology)</i> criteria, but has not met the exception criteria (Aii), offer to review for one of the Preferred Products using either the standard <i>Imatinib Prior Authorization Policy (General Oncology)</i> criteria <u>or</u> the <i>Dasatinib Prior Authorization Policy (General Oncology)</i> criteria.</p> <p><b>2. Other Conditions.</b> Approve for 1 year if the patient meets the standard <i>Bosulif Prior Authorization Policy (General Oncology)</i> criteria.</p>
<b>Iclusig</b>	<p><b>1. Philadelphia chromosome-positive Chronic Myeloid Leukemia (Ph+ CML).</b> Approve for 1 year if the patient meets the following (A <u>or</u> B):</p> <p><b>A)</b> Patient meets both of the following (i <u>and</u> ii):</p> <ul style="list-style-type: none"> <li><b>i.</b> Patient meets the standard <i>Iclusig Prior Authorization Policy (General Oncology)</i> criteria; AND</li> <li><b>ii.</b> Patient meets ONE of the following (a <u>or</u> b <u>or</u> c):           <ul style="list-style-type: none"> <li><b>a)</b> Patient has tried BOTH generic imatinib AND generic dasatinib; OR</li> <li><b>b)</b> Patient is currently receiving Iclusig; OR</li> <li><b>c)</b> Patient has Ph+ CML with T315I mutation; OR</li> </ul> </li> </ul> <p><b>B)</b> If the patient has met the standard <i>Iclusig Prior Authorization Policy (General Oncology)</i> criteria, but has not met the exception criteria (Aii), offer to review for one of the Preferred Products using either the standard <i>Imatinib Prior Authorization Policy (General Oncology)</i> criteria <u>or</u> the <i>Dasatinib Prior Authorization Policy (General Oncology)</i> criteria.</p> <p><b>2. Other Conditions.</b> Approve for 1 year if the patient meets the standard <i>Iclusig Prior Authorization Policy (General Oncology)</i> criteria.</p>
<b>Scemblix</b>	<p><b>1. Philadelphia chromosome-positive Chronic Myeloid Leukemia (Ph+ CML).</b> Approve for 1 year if the patient meets the following (A <u>or</u> B):</p> <p><b>A)</b> Patient meets both of the following (i <u>and</u> ii):</p> <ul style="list-style-type: none"> <li><b>i.</b> Patient meets the standard <i>Scemblix Prior Authorization Policy (General Oncology)</i> criteria; AND</li> <li><b>ii.</b> Patient meets ONE of the following (a <u>or</u> b <u>or</u> c):           <ul style="list-style-type: none"> <li><b>a)</b> Patient has tried BOTH generic imatinib AND generic dasatinib; OR</li> <li><b>b)</b> Patient is currently receiving Scemblix; OR</li> <li><b>c)</b> Patient has Ph+ CML with T315I mutation; OR</li> </ul> </li> </ul> <p><b>B)</b> If the patient has met the standard <i>Scemblix Prior Authorization Policy (General Oncology)</i> criteria, but has not met the exception criteria (Aii), offer to review for one of the Preferred</p>

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Non-Preferred Product	Exception Criteria
	<p>Products using either the standard <i>Imatinib Prior Authorization Policy (General Oncology)</i> criteria <b>or</b> the <i>Dasatinib Prior Authorization Policy (General Oncology)</i> criteria.</p> <p><b>2. Other Conditions.</b> Approve for 1 year if the patient meets the standard <i>Scemblix Prior Authorization Policy (General Oncology)</i> criteria.</p>
<p><b>Tasigna</b></p>	<p><b>1. Philadelphia chromosome-positive Chronic Myeloid Leukemia (Ph+ CML).</b> Approve for 1 year if the patient meets the following (A <b>or</b> B):</p> <p><b>A) Patient meets both of the following (i <b>and</b> ii):</b></p> <ul style="list-style-type: none"> <li><b>i.</b> Patient meets the standard <i>Tasigna Prior Authorization Policy (General Oncology)</i> criteria; <b>AND</b></li> <li><b>ii.</b> Patient meets <b>ONE</b> of the following (a <b>or</b> b): <ul style="list-style-type: none"> <li><b>a)</b> Patient has tried <b>BOTH</b> generic imatinib <b>AND</b> generic dasatinib; <b>OR</b></li> <li><b>b)</b> Patient is currently receiving Tasigna; <b>OR</b></li> </ul> </li> </ul> <p><b>B) If the patient has met the standard <i>Tasigna Prior Authorization Policy (General Oncology)</i> criteria, but has not met the exception criteria (Aii), offer to review for one of the Preferred Products using either the standard <i>Imatinib Prior Authorization Policy (General Oncology)</i> criteria <b>or</b> the <i>Dasatinib Prior Authorization Policy (General Oncology)</i> criteria.</b></p> <p><b>2. Other Conditions.</b> Approve for 1 year if the patient meets the standard <i>Tasigna Prior Authorization Policy (General Oncology)</i> criteria.</p>

**Initial Approval/ Extended Approval.**

- A) Initial Approval:** 1 year
- B) Extended Approval:** 1 year

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