



MEDICATION POLICY

Generic Name: Bosutinib

Therapeutic Class or Brand Name: Bosulif®

Applicable Drugs (if Therapeutic Class): N/A

Date of Origin: 2/1/13

Date Last Reviewed/Revised: 9/29/16

GPI Code: 2153401200

Prior Authorization Criteria (may be considered medically necessary when criteria I through V are met):

- I. Documented diagnosis of chronic, accelerated, or blast phase Chronic Myelogenous Leukemia (CML).
- II. Documentation that the patient's CML is Philadelphia chromosome-positive (Ph+).
- III. Documented trial and failure of, intolerance to, or contraindication to, one of the following other tyrosine kinase inhibitor (TKI) therapies for CML: dasatinib (Sprycel®), imatinib (Gleevec®), nilotinib (Tasigna®), or ponatinib (Iclusig®).
- IV. Minimum age requirement: 18 years old.
- V. The prescribing physician is an oncologist or a hematologist.

Exclusion Criteria:

- N/A

Other Criteria:

- N/A

Quantity/Days Supply Restrictions:

- Doses are limited to 600 mg per day. The quantity is limited to a maximum of a 30 day supply per fill.

Approval Length:

- **Authorization:** 1 year.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

Appendix:

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 judgment in providing the most appropriate care for their patients.



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N/A

References:

1. <http://blue.regence.com/trgmedpol/drugs/dru285.pdf>.
2. [Medi-Span](#).
3. <http://labeling.pfizer.com/ShowLabeling.aspx?id=884>.

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Historical Tracking Of Changes Made To Policy	
9/29/2016	1. Removed “ http://www.connecticare.com/provider/PDFs/Pharmacy/Bosulif.pdf ” from References (link no longer valid).
3/27/2015	1. Policy reviewed: no changes made.
11/25/2013	1. Adapted policy to new format. 2. Added GPI Code. 3. Changed “Documented diagnosis of Chronic Myelogenous Leukemia (CML)” to “Documented diagnosis of chronic, accelerated, or blast phase Chronic Myelogenous Leukemia (CML)” under Prior Authorization Criteria. 4. Added “intolerance to” to “Documented trial and failure of, intolerance to, or contraindication to, one of the following other tyrosine kinase inhibitor (TKI) therapies for CML: dasatinib (Sprycel®), imatinib (Gleevec®), nilotinib (Tasigna®), or ponatinib (Iclusig®)” under Prior Authorization Criteria. 5. Added “The prescribing physician is an oncologist or a hematologist” under Prior Authorization Criteria. 6. Updated references to include Medi-Span.

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