MEDICATION POLICY

Generic Name: Dasatinib

Therapeutic Class or Brand Name: Sprycel®

Applicable Drugs (if Therapeutic Class)**:** N/A

Date of Origin: 2/1/13 **Date Last Reviewed/Revised:** 12/7/17

GPI Code: 2153402000

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

I. Documented diagnosis of one of the following conditions A through C AND must meet criteria listed under applicable diagnosis:

A. Chronic, accelerated, or myeloid or lymphoid blast phase chronic myelogenous leukemia (CML) and criteria 1 and 2 are met:

1. Documented treatment failure, intolerance to, or contraindication to Gleevec® (imatinib).
2. Minimum age requirement: 18 years old.

B. Acute lymphoblastic leukemia (ALL) and criteria 1 and 2 are met:

1. Documented treatment failure, intolerance to, or contraindication to Gleevec® (imatinib).
2. Minimum age requirement: 18 years old.

C. Chronic myelogenous leukemia (CML) in chronic phase and criterion 1 is met:

1. Minimum body weight requirement: 10 kg.

II. Documentation that the patient's condition is Philadelphia chromosome-positive (Ph+).

III. 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 140mg per day. The quantity is limited to a maximum of a 30 day supply per fill.

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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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:

N/A

References:

1. http://blue.regence.com/trgmedpol/drugs/dru137.pdf.
2. Medi-Span.
3. http://packageinserts.bms.com/pi/pi_sprycel.pdf.

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Historical Tracking Of Changes Made To Policy	
12/7/2017	1. **Changed** "I. I. Documented diagnosis of one of the following conditions A through C AND must meet criteria listed under applicable diagnosis: A. Chronic, accelerated, or myeloid or lymphoid blast phase chronic myelogenous leukemia (CML) and criterion 1 is met: 1. Documented treatment failure, intolerance to, or contraindication to Gleevec® (imatinib); B. Acute lymphoblastic leukemia (ALL) and criterion 1 is met: 1. Documented treatment failure, intolerance to, or contraindication to Gleevec® (imatinib); C. Chronic myelogenous leukemia (CML) in chronic phase…III. Minimum age requirement: 18 years old" **to** "I. Documented diagnosis of one of the following conditions A through C AND must meet criteria listed under applicable diagnosis: A. Chronic, accelerated, or myeloid or lymphoid blast phase chronic myelogenous leukemia (CML) and criteria 1 and 2 are met: 1. Documented treatment failure, intolerance to, or contraindication to Gleevec® (imatinib); 2. Minimum age requirement: 18 years old; B. Acute lymphoblastic leukemia (ALL) and criteria 1 and 2 are met: 1. Documented treatment failure, intolerance to, or contraindication to Gleevec® (imatinib); 2. Minimum age requirement: 18 years old; C. Chronic myelogenous leukemia (CML) in chronic phase and criterion 1 is met: 1. Minimum body weight requirement: 10 kg" **under Prior Authorization Criteria**.
9/29/2016	1. **Removed** "http://www.connecticare.com/provider/PDFs/Pharmacy/Sprycel.pdf" **from References** (link no longer valid).
3/28/2015	1. Policy reviewed: no changes made.
11/25/2013	1. **Adapted policy to new format.** 2. **Added GPI Code**. 3. **Changed Prior Authorization Criteria from**: "Documented diagnosis of one the Covered Uses listed below AND must meet criteria listed under applicable diagnosis: Chronic or accelerated phase chronic myelogenous leukemia (CML): Documentation that the patient's CML is Philadelphia chromosome-positive (Ph+), Treatment with Tasigna® (nilotinib) is ineffective, not tolerated or contraindicated; Acute lymphoblastic leukemia (ALL): Documentation that the patient's ALL is Philadelphia chromosome-positive (Ph+). Treatment with Gleevec® (imatinib) is ineffective, not tolerated or contraindicated" **to:** "Documented diagnosis of one of the following conditions A through C AND must meet criteria listed under applicable diagnosis: A. Chronic, accelerated, or myeloid or lymphoid blast phase chronic myelogenous leukemia (CML) and criterion 1 is met: 1. Documented treatment failure, intolerance to, or contraindication to Gleevec® (imatinib). B. Acute lymphoblastic leukemia (ALL) and criterion 1 is met: 1. Documented treatment failure, intolerance to, or contraindication to Gleevec® (imatinib), C.Chronic myelogenous leukemia (CML) in chronic phase; Documentation that the patient's condition is Philadelphia chromosome-positive (Ph+); Minimum age requirement: 18 years old; The prescribing physician is an oncologist or a hematologist". 4. **Changed Quantity/Days Supply Restrictions from** "Authorized in quantities of up to 140 mg per day" **to** "Doses are limited to 140mg per day. The quantity is limited to a maximum of a 30 day supply per fill". 5. **Updated references** to include corrected website address for Regence policy, Connecticare policy, Medi-Span, and Sprycel package insert.

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