

Generic Name: Bosutinib

Preferred: N/A

Therapeutic Class or Brand Name: Bosulif®

Non-preferred: N/A

Applicable Drugs (if Therapeutic Class): N/A

Date of Origin: 2/1/2013

GPI Code: 2153401200

Date Last Reviewed / Revised: 8/14/2020

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

N/A

REFERENCES

1. <http://labeling.pfizer.com/ShowLabeling.aspx?id=884>.
2. https://www.accessdata.fda.gov/drugsatfda_docs/nda/2012/203341Orig1s000MedR.pdf.
3. Medi-Span

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.