MEDICATION POLICY:

Bosulif®

Generic Name: Bosutinib

Therapeutic Class or Brand Name: Bosulif®

Applicable Drugs (if Therapeutic Class): N/A

GPI Code: 2153401200

Preferred: N/A

Non-preferred: N/A

Date of Origin: 2/1/2013

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