

Generic Name: Ponatinib

Therapeutic Class or Brand Name: Iclusig®

Applicable Drugs (if Therapeutic Class): N/A

GPI Code: 2153407510

Preferred: N/A

Non-preferred: N/A

Date of Origin: 2/13/2013

Date Last Reviewed / Revised: 8/14/2020

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 or B AND must meet criteria listed under applicable diagnosis:
 - A. Chronic, accelerated, or blast phase Chronic Myelogenous Leukemia (CML) and ONE of criteria 1 or 2 is met:
 1. Documentation of a T315I mutation.
 2. Documentation that no other tyrosine kinase inhibitor (TKI) therapy is indicated.
 - B. Philadelphia chromosome positive Acute Lymphoblastic Leukemia (Ph+ ALL) and ONE of criteria 1 or 2 is met:
 1. Documentation of a T315I mutation.
 2. Documentation that no other tyrosine kinase inhibitor (TKI) therapy is indicated.
- II. Minimum age requirement: 18 years old.
- 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 45mg 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://iclusig.com/pi>.
2. 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.