MEDICATION POLICY:

Iclusig®

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.