

Generic Name: Asciminib**Preferred:** N/A**Therapeutic Class or Brand Name:** Scemblix®**Non-preferred:** N/A**Applicable Drugs (if Therapeutic Class):** N/A**Date of Origin:** 5/23/2022**Date Last Reviewed / Revised:** n/a

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I through IV are met)

- I. Documented diagnosis of the following condition AND must meet criteria listed under applicable diagnosis:
 - A. Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML) in chronic phase (CP) and BOTH criteria 1 and 2 are met:
 1. Documentation of a T315I mutation.
 2. Documented trial and failure of, intolerance to, or contraindication to the following therapies for CP-CML with a T315I mutation: ponatinib (Iclusig®), omacetaxine (Synribo®), or allogeneic hematopoietic cell transplantation.
- II. Documentation that no other tyrosine kinase inhibitor (TKI) therapy is indicated.
- III. Minimum age requirement: 18 years old.
- IV. The prescribing physician is an oncologist or a hematologist.

EXCLUSION CRITERIA

- N/A

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- For patients with Ph+ CML in CP: Doses are limited to 80 mg per day.
- For patients with Ph+ CML in CP with a T315I mutation: Doses are limited to 400 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. Scemblix [package insert]. Novartis Pharmaceuticals Corporation; East Hanover, NJ 07936; 2021.
2. Deeks ED. Asciminib: first approval. *Drugs*. 2022;82(2):219-226. doi:10.1007/s40265-021-01662-3
3. Réa D, Mauro MJ, Boquimpani C, et al. A phase 3, open-label, randomized study of asciminib, a STAMP inhibitor, vs bosutinib in CML after 2 or more prior TKIs. *Blood*. 2021;138(21):2031-2041. doi:10.1182/blood.2020009984
4. National Comprehensive Cancer Network (NCCN) Guidelines for Chronic Myeloid Leukemia Version 3.2022. Accessed 3/26/22.
5. 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.