



PHARMACY COVERAGE GUIDELINES
SECTION: DRUGS

ORIGINAL EFFECTIVE DATE: 01/01/16
LAST REVIEW DATE: 02/21/19
LAST CRITERIA REVISION DATE: 02/21/19
ARCHIVE DATE:

SPRYCEL® (dasatinib) oral tablet

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

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This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

SPRYCEL® (dasatinib) oral tablet (cont.)

Criteria:

- **Criteria for initial therapy:** Sprycel (dasatinib) is considered *medically necessary* and will be approved when **ALL** of the following criteria are met:
1. Prescriber is an Oncologist
 2. Individual is 18 years of age or older
 3. A confirmed diagnosis of **ONE** of the following:
 - Acute lymphoblastic leukemia (ALL) that is Philadelphia chromosome positive (Ph+) and **ONE** of the following:
 - Used for induction, consolidation or maintenance therapy
 - Used for relapsed/refractory disease in **one** of the following settings:
 - As single agent or in combination with an induction regimen not previously given
 - In patients with a Y253H, E255K/V, or F359V/C/I mutation
 - Chronic myeloid leukemia (CML) that is Philadelphia chromosome positive (Ph+) or Breakpoint Cluster Region Abelson Murine Leukemia (BCR-ABL) 1 fusion gene positive and **ONE** of the following:
 - Primary treatment of chronic phase CML or following resistance or intolerance to prior therapy
 - Treatment of advanced phase CML (accelerated phase or blast phase), as monotherapy or in combination with chemotherapy or steroids
 - Follow-up treatment after hematopoietic stem-cell transplant patients
 - Alternative treatment after imatinib, bosutinib, or nilotinib for BCR-ABL1 mutation profile Y253H, E255K/V or F359V/C/I
 - Treatment of BCR-ABL1 mutation profile Y253H, E255K/V or F359V/C/I
 - Maintenance treatment that follows BCR-ABL1 transcript level response milestones (See Definitions section)
 - Gastrointestinal Stromal Tumors (GIST) with PDGFRA D842V mutation that is progressive after single agent therapy with imatinib, sunitinib and regorafenib
 - Chondrosarcoma that is recurrent or metastatic, as a single agent
 - Other request for a specific oncologic direct treatment use that is found and listed in the National Comprehensive Cancer Network (NCCN) Guidelines with Categories of Evidence and Consensus of 1 and 2A

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SPRYCEL® (dasatinib) oral tablet (cont.)

Initial approval duration: 6 months

➤ **Criteria for continuation of coverage (renewal request):** Sprycel (dasatinib) is considered *medically necessary* and will be approved when **ALL** of the following criteria are met:

1. Continues to be seen by an Oncologist
2. The cancer has not progressed while on therapy
3. Individual has been adherent with the medication
4. Individual has not developed any contraindications or other significant level 4 adverse drug effects that may exclude continued use, such as:
 - Bleeding
 - Marked fluid retention
 - Pleural effusion
 - Pulmonary hypertension
5. There are no significant interacting drugs

Renewal duration: 6 months

Description:

Sprycel (dasatinib) is a kinase inhibitor is indicated for the treatment of adults with newly diagnosed with Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase; chronic, accelerated, or myeloid or lymphoid blast phase Ph+ CML with resistance or intolerance to prior therapy including imatinib; Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) with resistance or intolerance to prior therapy; and for the treatment of pediatric patients with Ph+ CML in chronic phase.

Dasatinib inhibits several kinases. It is predicted to bind to multiple conformations of the ABL kinase. *In vitro*, dasatinib was active in leukemic cell lines representing variants of imatinib-sensitive and -resistant disease. Dasatinib inhibited the growth of CML and ALL cell lines that overexpress BCR-ABL. Under the conditions of the assays, dasatinib was able to overcome imatinib-resistance resulting from BCR-ABL kinase domain mutations, activation of alternate signaling pathways involving the SRC family kinases (LYN, HCK), and multi-drug resistance gene overexpression.

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Definitions:

BCR-ABL1 (IS) Response Milestones:

BCR-ABL1 (IS)	3 months	6 months	12 months	> 12 months
> 10%	YELLOW	RED		
>1-10%	GREEN		YELLOW	RED
>0.1-1%	GREEN			YELLOW
≤ 0.1%	GREEN			
	Clinical considerations		2 nd line & subsequent treatment options	
Red	<ul style="list-style-type: none"> Evaluate compliance & drug interactions Mutational analysis 		<ul style="list-style-type: none"> Switch to alternate TKI Evaluate for HCT 	
Yellow	<ul style="list-style-type: none"> Evaluate compliance & drug interactions Mutational analysis 		<ul style="list-style-type: none"> Switch to alternate TKI or continue same TKI or dose escalation of imatinib (to max of 800 mg) Evaluate for HCT 	
Green	<ul style="list-style-type: none"> Monitor response & side effects 		<ul style="list-style-type: none"> Continue same TKI 	

Accelerated Phase CML:

Modified Criteria used at MD Anderson Cancer Center (most commonly used in clinical trials)
Peripheral blood blasts ≥ 15% and < 30%
Peripheral blood blasts and promyelocytes combined ≥ 30%
Peripheral blood basophils ≥ 20%
Platelet count ≤ 100 x 10 ⁹ /L unrelated to therapy
Additional clonal cytogenetic abnormalities in Ph+ cells
Semin Hematol 1988;25:49-61
Br J Haematol 1997;99:30-35
Blood 1993;82:691-703
Blood 2002;99:1928-1937

Blast Phase CML:

World Health Organization Criteria	International Bone Marrow Transplant Registry
Blasts ≥ 20% of peripheral white blood cells or of nucleated bone marrow cells	≥ 30% blasts in the blood, marrow, or both
Extramedullary blast proliferation	Extramedullary infiltrates or leukemic cells
Large foci or clusters of blasts in the bone marrow biopsy	
NCCN Chronic myeloid leukemia. Version 1.2018, July 26, 2017	

Treatment options based on BCR-ABL1 mutation profile:

Mutation	Treatment recommendations
E255K/V, F359V/C/I or Y253H	Dasatinib
F317L/V/I/C, T315A, or V299L	Nilotinib
E255K/V, F317L/V/I/C, F359V/C/I, T315A, or Y253H	Bosutinib
T315I	Ponatinib, Omacetaxine, allogeneic HCT, or clinical trial

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- Patients with disease that is resistant to primary treatment with imatinib should be treated with nilotinib, dasatinib, or bosutinib in the second-line setting.
- Patients with disease that is resistant to primary treatment with nilotinib or dasatinib could be treated with an alternative TKI (other than imatinib) in the second-line setting.
- Ponatinib is also a treatment option for patients for whom no other TKI is indicated.
- Omacetaxine is a treatment option for patients with disease that is resistant and/or intolerant to 2 or more TKIs.

Definitions for response and relapse in CML:

CHR	Complete normalization of peripheral blood counts with leukocyte count < 10 x 10 ⁹ /L Platelet count < 450 x 10 ⁹ /L No immature cells (such as myelocytes, promyelocytes, or blasts) in peripheral blood No signs & symptoms of disease, with disappearance of palpable splenomegaly
CyR	Complete CyR (CCyR): no Ph+ metaphases (correlates to <i>BCR-ABL</i> (IS) ≤ 1% (> 0.1-1%)) Partial CyR (PCyR): 1-35% Ph+ metaphases Major CyR: 0-35% Ph+ metaphases Minor CyR: > 35% Ph+ metaphases No response: > 95% Ph+ metaphases
MR	Early MR (EMR) – <i>BCR-ABL</i> (IS) ≤ 10% at 3 and 6 months Major MR (MMR) – <i>BCR-ABL</i> (IS) ≤ 0.1% or ≥ 3 log reduction in <i>BCR-ABL1</i> mRNA from the standardized baseline, if qPCR (IS) is not available Complete MR (CMR) – is variably described, and is best defined by the assay's level of sensitivity (such as MR 4.5)
Relapse	Any sign of loss of response define as hematologic or cytogenetic 1 log increase in <i>BCR-ABL1</i> transcript levels with loss of MMR should prompt bone marrow evaluation for loss of CCyR but is not itself defined as relapse (hematologic or cytogenetic relapse)
CHR: complete hematologic response CyR: cytogenetic response MR: molecular response IS: International scale – the ratio of the <i>BCR-ABL1</i> transcriptions to <i>ABL1</i> transcripts	

Molecular response International Scale:

International Scale (IS)	
MR 2	Detectable disease at a level of ≤ 1% on the IS (≥ 2 log reduction from the standardized baseline). This level of response roughly corresponds to a "complete cytogenetic response"
MR 3	Detectable disease at a level of ≤ 0.1% on the IS (≥ 3 log reduction from the standardized baseline). This level of response has been termed a "major molecular response"
MR 4	Either detectable disease at a level of ≤ 0.01% on the IS (≥ 4 log reduction) or undetectable disease in cDNA with ≥ 10,000 <i>ABL1</i> transcripts. This level of response requires that the assay being used is sensitive enough to detect a single abnormal transcript amongst 10,000 normal <i>ABL1</i> transcripts
MR 4.5	Either detectable disease at a level of ≤ 0.0032% on the IS (≥ 4.4 log reduction) or undetectable disease in cDNA with ≥ 32,000 <i>ABL1</i> transcripts. This level of response requires that the assay being used is sensitive enough to detect a single abnormal transcript amongst 32,000 normal <i>ABL1</i> transcripts

Monitoring Response to TKI Therapy and Mutational Analysis:

Test	Recommendation
Bone marrow cytogenetic	<ul style="list-style-type: none"> • At diagnosis

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	<ul style="list-style-type: none"> • Failure to reach response milestone • Any signs of loss of response (defined as hematologic or cytogenetic relapse)
Quantitative RT-PCT (qPCR) using IS	<ul style="list-style-type: none"> • At diagnosis • Every 3 months after initiating treatment. After <i>BCR-ABL1</i> (IS) $\leq 1\%$ ($> 0.1-1\%$) has been achieved, every 3 months x 2 y and every 3-6 months thereafter • If there is a 1-log increase in <i>BCR-ABL1</i> transcript levels with MMR, qPCR should be repeated in 1-3 months
BCR-ABL1 kinase domain mutation analysis	<ul style="list-style-type: none"> • Chronic phase <ul style="list-style-type: none"> ➢ Failure to reach response milestone ➢ Any signs of loss of response (defined as hematologic or cytogenetic relapse) ➢ 1-log increase in <i>BCR-ABL1</i> transcript levels and loss of MMR • Disease progression to accelerated or blast phase

Resources:

NCCN Drugs & Biologics Compendium Sprycel accessed 02-01-19

Sprycel. Package Insert. Revised by manufacturer 05/2014. Accessed 08-04-2015.

Sprycel. Package Insert. Revised by manufacturer 10/2015. Accessed 07-22-2016.

Sprycel. Package Insert. Revised by manufacturer 04/2017. Accessed 07-27-2017.

Sprycel. Package Insert. Revised by manufacturer 11/2017. Accessed 02-23-2018.

NCCN Clinical Practice Guidelines in Oncology: Chronic myeloid leukemia. Version 01.2018, July 26, 2017. https://www.nccn.org/professionals/physician_gls/pdf/cml.pdf

UpToDate: Overview of the treatment of chronic myeloid leukemia. Current through Aug 2017. https://www-uptodate-com.mwu.idm.oclc.org/contents/overview-of-the-treatment-of-chronic-myeloid-leukemia?source=search_result&search=chronic%20myeloid%20leukemia&selectedTitle=2~150

UpToDate: Initial treatment of chronic myeloid leukemia in chronic phase. Current through Aug 2017. https://www-uptodate-com.mwu.idm.oclc.org/contents/initial-treatment-of-chronic-myeloid-leukemia-in-chronic-phase?source=see_link#H15

UpToDate: Treatment of chronic myeloid leukemia in chronic phase after failure of initial therapy. Current through Aug 2017. https://www-uptodate-com.mwu.idm.oclc.org/contents/treatment-of-chronic-myeloid-leukemia-in-chronic-phase-after-failure-of-initial-therapy?source=search_result&search=chronic%20myeloid%20leukemia&selectedTitle=4~150

NCCN Clinical Practice Guidelines in Oncology: Acute lymphoblastic leukemia. Version 02.2017, Aug 30, 2017. https://www.nccn.org/professionals/physician_gls/pdf/all.pdf

UpToDate: Induction therapy for Philadelphia chromosome positive acute lymphoblastic leukemia in adults. Current through Aug 2017. https://www-uptodate-com.mwu.idm.oclc.org/contents/induction-therapy-for-philadelphia-chromosome-positive-acute-lymphoblastic-leukemia-in-adults?source=see_link#H60604746



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Off Label Use of Cancer Medications: A.R.S. §§ 20-826(R) & (S). Subscription contracts; definitions.

Off Label Use of Cancer Medications: A.R.S. §§ 20-1057(V) & (W). Evidence of coverage by health care service organizations; renewability; definitions.



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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com. Call 866-325-1794 to check the status of a request. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information			
Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information			
Medication Name:	Strength:	Dosage Form:	
Directions for Use:	Quantity:	Refills:	Duration of Therapy/Use:

Check if requesting **brand** only Check if requesting **generic**

Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review	
<input type="checkbox"/> Standard <input type="checkbox"/> Urgent. Sign here: _____	<input type="checkbox"/> Exigent (requires prescriber to include a written statement)

Clinical Information	
1. What is the diagnosis? Please specify below. ICD-10 Code: _____ Diagnosis Description: _____	
2. <input type="checkbox"/> Yes <input type="checkbox"/> No	Was this medication started on a recent hospital discharge or emergency room visit?
3. <input type="checkbox"/> Yes <input type="checkbox"/> No	There is absence of ALL contraindications.

4. What medication(s) has the individual tried and failed for this diagnosis? Please specify below.
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. Are there any supporting labs or test results? Please specify below.

Date	Test	Value

Pharmacy Prior Authorization Request Form

6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature:	Date:
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Please note: Some medications may require completion of a drug-specific request form.

Incomplete forms or forms without the chart notes will be returned.

Office notes, labs, and medical testing relevant to the request that show medical justification are required.