MEDICAL MUTUAL®

Drug Policy

Policy:	**Oncology Care Value Preferred Specialty Management**	**Annual Review Date:** **11/21/2024**
Impacted Drugs:	**Bosulif** **Braftovi** **Ibrance** **Iclusig** **Lupron Depot 7.5 mg, 22.5 mg, 30 mg, 45 mg** **Mektovi** **Orgovyx** **Scemblix** **Tasigna**	**Last Revised Date:** **02/20/2025**

OVERVIEW

This Care Value policy involves the use of antineoplastic agents used in the treatment and management of oncologic conditions. This policy does **not** include the requirement of a generic trial for multi-source brand (MSB) oncology agents.

POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of a Preferred Product prior to a Non-Preferred Product. For all medications (Preferred and Non-Preferred), the patient is required to meet the respective standard *Prior Authorization Policy* criteria and to try the Preferred Products prior to the approval of a Non-Preferred Product. Requests for the Non-Preferred Product will be reviewed using the exception criteria (below). If the patient meets the standard *Prior Authorization Policy* criteria for the Non-Preferred Product, but has not tried the Preferred Products, a review will be offered for the Preferred Products using the respective standard *Prior Authorization Policy* criteria. All approvals are provided for the duration noted below.

Automation: None.

Melanoma

BRAF Inhibitors:

Preferred Products	Zelboraf, Tafinlar
Non-Preferred Product	Braftovi

MEK Inhibitors:

Preferred Products	Cotellic, Mekinist
Non-Preferred Product	Mektovi

Non-Small Cell Lung Cancer (NSCLC)

BRAF Inhibitors:

Preferred Product	Tafinlar
Non-Preferred Product	Braftovi

MEK Inhibitors:

Preferred Product	Mekinist
Non-Preferred Product	Mektovi

Prostate Cancer

Preferred Product	Eligard
Non-Preferred Product	Orgovyx, Lupron Depot (7.5 mg, 22.5 mg, 30 mg, 45 mg only)

Breast Cancer

Preferred Products	Verzenio, Kisqali, Kisqali Femara Co-Pack
Non-Preferred Product	Ibrance

Chronic Myeloid Leukemia (CML)

Preferred Products	generic imatinib, generic dasatinib
Non-Preferred Products	Bosulif, Tasigna, Iclusig, Scemblix

RECOMMENDED EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Braftovi	**1. Melanoma, BRAF V600 Mutation-Positive Disease:** Approve for 1 year if the patient meets ONE of the following (A or B): **A)** Patient meets BOTH of the following: **i.** Patient meets the standard *Braftovi Prior Authorization Policy (General Oncology)* criteria; AND **ii.** Patient meets ONE of the following (a or b): **a)** Patient has tried one of Zelboraf or Tafinlar; OR **b)** Patient is currently receiving Braftovi; OR **B)** If the patient has met the standard *Braftovi Prior Authorization Policy (General Oncology)* criteria, but has not met the exception criteria above (Aii), offer to review for one of the Preferred Products using either the standard *Zelboraf Prior Authorization Policy (General Oncology)* criteria **or** the *Tafinlar Prior Authorization Policy (General Oncology)* criteria.

Non-Preferred Product	Exception Criteria
	2. Non-Small Cell Lung Cancer, BRAF V600E Mutation-Positive Disease: Approve for 1 year if the patient meets ONE of the following (A or B): **A)** Patient meets BOTH of the following: **i.** Patient meets the standard *Braftovi Prior Authorization Policy (General Oncology)* criteria; AND **ii.** Patient meets ONE of the following (a or b): **a)** Patient has tried Tafinlar; OR **b)** Patient is currently receiving Braftovi; OR **B)** If the patient has met the standard *Braftovi Prior Authorization Policy (General Oncology)* criteria, but has not met the exception criteria above (Aii), offer to review for the Preferred Product using the standard *Tafinlar Prior Authorization Policy (General Oncology)* criteria. **3. Other Conditions:** Approve for 1 year if the patient meets the standard *Braftovi Prior Authorization Policy (General Oncology)* criteria.
Mektovi	**1. Melanoma, BRAF V600 Mutation-Positive Disease:** Approve for 1 year if the patient meets ONE of the following (A or B): **A)** Patient meets BOTH of the following: **i.** Patient meets the standard *Mektovi Prior Authorization Policy (General Oncology)* criteria; AND **ii.** Patient meets ONE of the following (a or b): **a)** Patient has tried one of Cotellic or Mekinist; OR **b)** Patient is currently receiving Mektovi; OR **B)** If the patient has met the standard *Mektovi Prior Authorization Policy (General Oncology)* criteria, but has not met the exception criteria above (Aii), offer to review for one of the Preferred Products using either the standard *Cotellic Prior Authorization Policy (General Oncology)* criteria **or** the *Mekinist Prior Authorization Policy (General Oncology)* criteria. **2. Non-Small Cell Lung Cancer, BRAF V600E Mutation-Positive Disease:** Approve for 1 year if the patient meets ONE of the following (A or B): **A)** Patient meets BOTH of the following: **i.** Patient meets the standard *Mektovi Prior Authorization Policy (General Oncology)* criteria; AND **ii.** Patient meets ONE of the following (a or b): **a)** Patient has tried Mekinist; OR **b)** Patient is currently receiving Mektovi; OR **B)** If the patient has met the standard *Mektovi Prior Authorization Policy (General Oncology)* criteria, but has not met the exception criteria above (Aii), offer to review for the Preferred Product using the standard *Mekinist Prior Authorization Policy (General Oncology)* criteria. **3. Other Conditions:** Approve for 1 year if the patient meets the standard *Mektovi Prior Authorization Policy (General Oncology)* criteria.
Lupron Depot (7.5 mg, 22.5	**1. Prostate Cancer, Advanced:** Approve for 1 year if the patient meets ONE of the following (A or B):

Non-Preferred Product	Exception Criteria
mg, 30 mg, 45 mg only)	**A)** Patient meets BOTH of the following: **i.** Patient meets the standard *Lupron Depot Prior Authorization Policy (Gonadotropin-Releasing Hormone Agonists- Injectable Long-Acting Products)* criteria; AND **ii.** Patient meets ONE of the following (a or b): **a)** Patient has tried Eligard; OR **b)** Patient is currently receiving Lupron Depot 7.5 mg, 22.5 mg, 30 mg or 45 mg; OR **B)** If the patient has met the standard *Lupron Depot Prior Authorization Policy (Gonadotropin-Releasing Hormone Agonists- Injectable Long-Acting Products)* criteria, but has not met the exception criteria above (Aii), offer to review for the Preferred Product using the standard *Eligard Prior Authorization Policy (General Oncology)* criteria. **2. Other Conditions:** Approve for 1 year if the patient meets the standard *Lupron Depot Prior Authorization Policy (Gonadotropin-Releasing Hormone Agonists- Injectable Long-Acting Products)* criteria.
Orgovyx	**1. Prostate Cancer, Advanced:** Approve for 1 year if the patient meets ONE of the following (A or B): **A)** Patient meets BOTH of the following: **i.** Patient meets the standard *Orgovyx Prior Authorization Policy (General Oncology)* criteria; AND **ii.** Patient meets ONE of the following (a or b): **a)** Patient has tried Eligard; OR **b)** Patient is currently receiving Orgovyx; OR **B)** If the patient has met the standard *Orgovyx Prior Authorization Policy (General Oncology)* criteria, but has not met the exception criteria above (Aii), offer to review for the Preferred Product using the standard *Eligard Prior Authorization Policy (General Oncology)* criteria. **2. Other Conditions:** Approve for 1 year if the patient meets the standard *Orgovyx Prior Authorization Policy (General Oncology)* criteria.
Ibrance	**1. Breast Cancer.** Approve for 1 year if the patient meets the following (A or B): **A)** Patient meets both of the following (i and ii): **i.** Patient meets the standard *Ibrance Prior Authorization Policy (General Oncology)* criteria; AND **ii.** Patient meets ONE of the following (a or b): **a)** Patient has been taking Ibrance and is continuing therapy; OR **b)** Patient has tried one of Kisqali, Kisqali Femara Co-Pack, or Verzenio; OR **B)** If the patient has met the standard *Ibrance Prior Authorization Policy (General Oncology)* criteria, but has not met the exception criteria (Aii), offer to review for one of the Preferred Products using either the standard *Kisqali Prior Authorization Policy* criteria **or** the standard *Kisqali Femara Co-Pack Prior Authorization Policy (General Oncology)* criteria **or** the standard *Verzenio Prior Authorization Policy (General Oncology)* criteria. **2. Other Conditions**. Approve for 1 year if the patient meets the standard *Ibrance Prior Authorization Policy (General Oncology)* criteria.

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Non-Preferred Product	Exception Criteria
Bosulif	**1. Philadelphia chromosome-positive Chronic Myeloid Leukemia (Ph+ CML).** Approve for 1 year if the patient meets the following (A or B): **A)** Patient meets both of the following (i and ii): **i.** Patient meets the standard *Bosulif Prior Authorization Policy (General Oncology)* criteria; AND **ii.** Patient meets ONE of the following (a or b): **a)** Patient has tried BOTH generic imatinib AND generic dasatinib; OR **b)** Patient is currently receiving Bosulif; OR **B)** If the patient has met the standard *Bosluif Prior Authorization Policy (General Oncology)* criteria, but has not met the exception criteria (Aii), offer to review for one of the Preferred Products using either the standard *Imatinib Prior Authorization Policy (General Oncology)* criteria **or** the *Dasatinib Prior Authorization Policy (General Oncology)* criteria. **2. Other Conditions**. Approve for 1 year if the patient meets the standard *Bosulif Prior Authorization Policy (General Oncology)* criteria.
Iclusig	**1. Philadelphia chromosome-positive Chronic Myeloid Leukemia (Ph+ CML).** Approve for 1 year if the patient meets the following (A or B): **A)** Patient meets both of the following (i and ii): **i.** Patient meets the standard *Iclusig Prior Authorization Policy (General Oncology)* criteria; AND **ii.** Patient meets ONE of the following (a or b or c): **a)** Patient has tried BOTH generic imatinib AND generic dasatinib; OR **b)** Patient is currently receiving Iclusig; OR **c)** Patient has Ph+ CML with T315I mutation; OR **B)** If the patient has met the standard *Iclusig Prior Authorization Policy (General Oncology)* criteria, but has not met the exception criteria (Aii), offer to review for one of the Preferred Products using either the standard *Imatinib Prior Authorization Policy (General Oncology)* criteria **or** the *Dasatinib Prior Authorization Policy (General Oncology)* criteria. **2. Other Conditions**. Approve for 1 year if the patient meets the standard *Iclusig Prior Authorization Policy (General Oncology)* criteria.
Scemblix	**1. Philadelphia chromosome-positive Chronic Myeloid Leukemia (Ph+ CML).** Approve for 1 year if the patient meets the following (A or B): **A)** Patient meets both of the following (i and ii): **i.** Patient meets the standard *Scemblix Prior Authorization Policy (General Oncology)* criteria; AND **ii.** Patient meets ONE of the following (a or b or c): **a)** Patient has tried BOTH generic imatinib AND generic dasatinib; OR **b)** Patient is currently receiving Scemblix; OR **c)** Patient has Ph+ CML with T315I mutation; OR **B)** If the patient has met the standard *Scemblix Prior Authorization Policy (General Oncology)* criteria, but has not met the exception criteria (Aii), offer to review for one of the Preferred

Non-Preferred Product	Exception Criteria
	Products using either the standard *Imatinib Prior Authorization Policy (General Oncology)* criteria **or** the *Dasatinib Prior Authorization Policy (General Oncology)* criteria. **2. Other Conditions**. Approve for 1 year if the patient meets the standard *Scemblix Prior Authorization Policy (General Oncology)* criteria.
Tasigna	**1. Philadelphia chromosome-positive Chronic Myeloid Leukemia (Ph+ CML).** Approve for 1 year if the patient meets the following (A or B): **A)** Patient meets both of the following (i and ii): **i.** Patient meets the standard *Tasigna Prior Authorization Policy (General Oncology)* criteria; AND **ii.** Patient meets ONE of the following (a or b): **a)** Patient has tried BOTH generic imatinib AND generic dasatinib; OR **b)** Patient is currently receiving Tasigna; OR **B)** If the patient has met the standard *Tasigna Prior Authorization Policy (General Oncology)* criteria, but has not met the exception criteria (Aii), offer to review for one of the Preferred Products using either the standard *Imatinib Prior Authorization Policy (General Oncology)* criteria **or** the *Dasatinib Prior Authorization Policy (General Oncology)* criteria. **2. Other Conditions**. Approve for 1 year if the patient meets the standard *Tasigna Prior Authorization Policy (General Oncology)* criteria.

Initial Approval/ Extended Approval.
A) *Initial Approval:* 1 year
B) *Extended Approval:* 1 year

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