

Title

Oncology, Oral
Sprycel[®] (dasatinib)
Sutent[®] (sunitinib)
Tasigna[®] (nilotinib)

Prescription Drug Step Therapy

Note: All requests for **outpatient retail pharmacy** for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the **Prior Authorization Form** on the last page of this document. Physicians may also call BCBSMA Pharmacy Operations department to request a review for prior authorization for patients at (800)366-7778. Patients must have pharmacy benefits under their subscriber certificates.

Drug	Formularies	
	Standard	Blue Value Rx
	Formulary Status	Formulary Status
Sprycel [®]	PA required	PA required
Sutent [®]	PA required	PA required
Tasigna [®]	PA required	PA required

When services are covered

Sprycel[®] (dasatinib):

We cover Sprycel[®] (dasatinib) for a documented diagnosis of chronic, accelerated myeloid or lymphoid blast phase of chronic myeloid leukemia (CML) when **all** the following criteria are met:

- Patient is 18 years of age or over
- Patient has had previous resistance or intolerance to Gleevec[®] (imatinib)

OR

- The patient has had a BCBSMA paid claim for Sprycel[®] within the previous 130 days.

We cover Sprycel[®] (dasatinib) for a documented diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) when **all** the following criteria are met:

- Patient is 18 years of age or over
- Patient has had previous resistance or intolerance to Gleevec[®] (imatinib)

OR

- The patient has had a BCBSMA paid claim for Sprycel[®] within the previous 130 days.

Sutent® (sunitinib):

We cover Sutent® (sunitinib) for a documented diagnosis of advanced renal cell carcinoma when **all** the following criteria are met:

- Patient is 18 years of age or over

We cover Sutent® (sunitinib) for a documented diagnosis of gastrointestinal stromal tumor when all the following criteria are met:

- Patient is 18 years of age or over
- Patient has had previous resistance or intolerance to Gleevec® (imatinib)

OR

- The patient has had a BCBSMA paid claim for Sutent® within the previous 130 days.

Tasigna® (nilotinib)

We cover Tasigna® (nilotinib) for a documented diagnosis of chronic phase and accelerated phase Philadelphia chromosome positive chronic myelogenous leukemia (Ph+ CML) when **all** the following criteria are met:

- Patient is 18 years of age or over
- Patient has had previous resistance or intolerance to Gleevec® (imatinib)

OR

- The patient has had a BCBSMA paid claim for Tasigna® within the previous 130 days.

When services are not covered

We do not cover the above drugs for the listed diagnoses that have not met the coverage criteria above.

Individual consideration

All our policies are written for the majority of people with given conditions. For many of our policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. Prescribers may send relevant clinical information for individual patients for coverage consideration to:

Blue Cross Blue Shield of Massachusetts
Clinical Pharmacy Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-800-583-6289

Managed care, PPO and Indemnity guidelines

Prior Authorization is required for all plans as these drugs are processed as a Pharmacy benefit.

- Physicians may call BCBSMA Pharmacy Operations department to request a review for prior authorization for patients:
Pharmacy Operations: (800)366-7778
- Physicians may also fax or mail the attached form to the address above. The Formulary Exception/Prior Authorization form is included as part of this document for physicians to submit for prior authorization.

Coding information

Physician billing is not applicable as these medications are billed through the pharmacy benefit.

Other information

Blue Cross Blue Shield of Massachusetts (BCBSMA*) members (other than Medex®; Blue MedicareRx, Blue Health Plan for Kids; Medicare Advantage plans that include prescription drug coverage; closed non-group

plans) will be required to fill their prescriptions for oral oncology at one of the four providers in our retail specialty pharmacy network, as listed below:

Caremark, Inc.	CuraScript™ Pharmacy, Inc., a subsidiary of Express Scripts, Inc.	IVPCARE®, a Walgreens Specialty Company	SpecialtyScripts Pharmacy
Phone: 1-866-846-3096 Fax: 1-800-323-2445 Website: www.caremark.com	Phone: 1-888-823-9070 Fax: 1-888-773-7386 Website: www.curascript.com	Phone: 1-800-370-2510 Fax: 1-800-874-9179 Website: www.ivpcare.com	Phone: 1-800-218-5688 Fax: 1-800-830-5292 Website: www.specialtyscripts.com
7:30 a.m. – 9:00 p.m. EST	8:00 a.m. – 9:00 p.m. EST (M-F); 9:00 a.m. – 1:00 p.m. EST (Sat.)	8:00 a.m. – 9:00 p.m. EST (M-F); 10:00 a.m. – 4:00 p.m. EST (Sat.)	8:30 a.m. – 7:00 p.m. EST

Policy update history

Policy developed 1/09. Policy updated 09/09 to change 180 day look back period to 130 days and remove Medicare Part D from medical policy. Reviewed 9/2009 MPG-Hematology and Oncology, no changes in coverage were made.

Scientific background, Rationale and References

¹Based on the recommendations of the BCBSMA Pharmacy and Therapeutics Committee meeting on 05/13/08.

References:

1. Sprycel® [package insert]. Princeton, NJ: Bristol-Myers Squibb; May 2008.
2. Sutent® [package insert]. New York, NY: Pfizer; May 2008.
3. Tasigna® [package insert]. East Hanover, NJ: Novartis; October 2007.

This document is designed for informational purposes only and is not an authorization, or an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical technology is constantly changing, and we reserve the right to review and update our policies periodically.

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Request for Outpatient Retail Pharmacy Prior Authorization

Fax to: Clinical Pharmacy Program (800) 583-6289

Phone Authorization (800)366-7778

We plan to respond to your request within two business days of our receipt. To ensure that we can confirm your request (required by NCQA), please be sure to include your fax number.

We cannot process requests unless they contain all of the information requested below:	
Patient Information (REQUIRED)	
Name	
BCBSMA ID number	
Is the patient a BCBSMA employee? If yes, please fax request to: (617) 246-4013	Yes No
Date of Birth	
Patient's Diagnosis or ICD-9-CM code	
Physician Information (REQUIRED)	
Name	
Medical Specialty	
BCBSMA Provider number/NPI number	
Telephone Number	
Fax Number	
Contact Name (if different from physician)	
Please select one of the three following sections to complete, depending on the nature of your request for the above-named patient.	
Formulary Exception Request	
Name of non-covered drug you want to prescribe	
Reason for Individual Consideration Request (please check one): <input type="checkbox"/> Treatment failure with the following covered drugs in class <input type="checkbox"/> Documented adverse reaction to the following covered drugs <input type="checkbox"/> Other clinical reason (please specify) _____	
Quality Care Dosing Override Request	
Drug name, strength and quantity requested:	
Clinical reason for override (please specify)	
Outpatient Retail Pharmacy Prior Authorization Request	
Drug name:	
Start/End date (must be one year or less):	
Associated Co-morbid diagnosis:	
For Epogen®/Procrit® only:	GFR:
	Is patient certified ESRD with Medicare? Yes No
MD Signature:	Date: