

## Pharmacy Medical Necessity Guidelines: Antineoplastics

Effective: May 1, 2025

Prior Authorization Required	✓	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	✓
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: <input checked="" type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan		<b>Fax Numbers:</b> RXUM: 617.673.0939	

**Note:** This guideline does not apply to Medicare Members (includes dual eligible Members).

### OVERVIEW

The following oral cancer medications require prior authorization:

- abiraterone
- Akeega (niraparib/abiraterone)
- Alecensa (alectinib)
- Alunbrig (brigatinib)
- Augtyro (repotrectinib)
- Ayvakit (avapritinib)
- Balversa (erdafitinib)
- Bosulif (bosutinib)
- Braftovi (encorafenib)
- Brukinsa (zanubrutinib)
- Cabometyx (cabozantinib)
- Calquence (acalabrutinib)
- Caprelsa (vandetanib)
- Cometriq (cabozantinib)
- Copiktra (duvelisib)
- Cotellic (cobimetinib)
- Daurismo (glasdegib)
- Erivedge (vismodegib)
- Everolimus tablet
- Everolimus tablets for oral suspension
- Exkivity (mobocertinib)
- Farydak (panobinostat)
- Fotivda (tivozanib)
- Fruzaqla (fruquintinib)
- Gavreto (pralsetinib)
- Gilotrif (afatinib)
- Hycamtin (topotecan)
- Ibrance (palbociclib)
- Iclusig (ponatinib)
- Idhifa (enasidenib)
- Imbruvica (ibrutinib)
- Inlyta (axitinib)
- Inqovi (decitabine/cedazuridine)
- Inrebic (fedratinib)
- Iressa (gefitinib)
- Itovebi (inavolisib)
- Iwilfin (eflornithine)
- Jakafi (ruxolitinib)
- Jaypirca (pirtobrutinib)
- Kisqali (ribociclib)
- Koselugo (selumetinib)
- Krazati (adagrasib)
- Lazcluze (lazertinib)
- Lenvima (lenvatinib)
- Lonsurf (trifluridine/tipiracil)
- Lorbrena (lorlatinib)
- Lumakras (sotorasib)
- Lynparza (olaparib)
- Lytgobi (futibatinib)
- Mekinist (trametinib)
- Mektovi (binimetinib)
- Nexavar (sorafenib)
- Nerlynx (neratinib)
- Ninlaro (ixazomib)
- Odomzo (sonidegib)
- Ogsiveo (nirogacestat)
- Ojemda (tovoraenib)
- Ojjaara (momeotinib)
- Onureg (azacytidine)
- Orgovyx (relugolix)
- Orserdu (elacestrant)
- Pemazyre (pemigatinib)
- Piqray (alpelisib)
- Pomalyst (pomalidomide)
- Qinlock (ripretinib)
- Retevmo (selpercatinib)
- Revlimid (lenalidomide)
- Revuforj (revumenib)
- Rezlidhia (olutasidenib)
- Rozlytrek (entrectinib)
- Rubraca (rucaparib)
- Rydapt (midostaurin)
- Scemblix (asciminib)
- Sprycel (dasatinib)
- Stivarga (regorafenib)
- Sutent (sunitinib)
- Tabrecta (capmatinib)
- Tafinlar (dabrafenib)
- Tagrisso (osimertinib)
- Talzenna (talazoparib)
- Tasigna (nilotinib)
- Tazverik (tazemetostat)
- Tepmetko (tepotinib)
- Tibsovo (ivosidenib)
- Truqap (capivasertib)
- Truseltiq (infigratinib)
- Tukysa (tucatinib)
- Turalio (pexidartinib)
- Tykerb (lapatinib)
- Vanflyta (quizartinib)
- Venclexta (venetoclax)
- Verzenio (abemaciclib)
- Vitrakvi (larotrectinib)
- Vizimpro (dacomitinib)

- Vonjo (pacritinib)
- Voranigo (vorasidenib)
- Votrient (pazopanib)
- Welireg (belzutifan)
- Xalkori (crizotinib)
- Xpovio (selinexor)
- Xtandi (enzalutamide)
- Xospata (gilteritinib)
- Zejula (niraparib)
- Zelboraf (vemurafenib)
- Zolanza (vorinostat)
- Zydelig (idelalisib)
- Zykadia (ceritinib)

## COVERAGE GUIDELINES

### Abiraterone

The plan may authorize coverage of abiraterone for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of one of the following:
  - a) Metastatic castration-resistant prostate-cancer
  - b) Metastatic high-risk castration-sensitive prostate cancer

**AND**

2. The prescribing physician is an oncologist or urologist

**AND**

3. Documentation that treatment is in combination with prednisone

### Akeega (niraparib and abiraterone)

The plan may authorize coverage of Akeega for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of metastatic castration-resistant prostate cancer

**AND**

2. Documentation of deleterious or suspected deleterious BRCA-mutated cancer

**AND**

3. Documentation of use in combination with prednisone

**AND**

4. The prescribing physician is an oncologist

### Alecensa (alectinib)

The plan may authorize coverage of Alecensa (alectinib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of anaplastic lymphoma kinase-positive, metastatic non-small cell lung cancer as detected by an FDA-approved test

**AND**

2. The prescribing physician is an oncologist

### Alunbrig (brigatinib)

The plan may authorize coverage of Alunbrig (brigatinib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of anaplastic lymphoma kinase-positive metastatic non-small cell lung cancer as detected by an Food and Drug Administration-approved test

**AND**

2. The prescribing physician is an oncologist

### Augtyro (repotrectinib)

The plan may authorize coverage of Augtyro (repotrectinib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of local advanced or metastatic ROS1-positive non-small cell lung cancer

**AND**

2. The prescribing physician is an oncologist

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**Ayvakit (avapritinib)**

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The plan may authorize coverage of Ayvakit (avapritinib) for Members, when **ALL** of the following criteria are met:

**Advanced Systemic Mastocytosis**

1. Documented diagnosis of advanced systemic mastocytosis

**AND**

2. The prescribing physician is an oncologist, hematologist, immunologist, or allergist

**Gastrointestinal Stromal Tumor**

1. Documented diagnosis of unresectable or metastatic gastrointestinal stromal tumor

**AND**

2. Documentation of platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation

**AND**

3. The prescribing physician is an oncologist

**Indolent Systemic Mastocytosis**

1. Documented diagnosis of indolent systemic mastocytosis

**AND**

2. The prescribing physician is an oncologist, hematologist, immunologist, or allergist

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**Balversa (erdafitinib)**

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The plan may authorize coverage of Balversa (erdafitinib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of metastatic urothelial carcinoma

**AND**

2. Documentation of susceptible FGFR3 or FGFR2 genetic alternations

**AND**

3. Documentation of disease progression following  $\geq 1$  line of prior platinum-containing chemotherapy

**AND**

4. The prescribing physician is an oncologist

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**Bosulif (bosutinib)**

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The plan may authorize coverage of Bosulif (bosutinib) for Members when **ALL** of the following criteria are met:

1. The prescribing physician is an oncologist or hematologist

**AND**

2. Documentation of one of the following:

- a) Documented diagnosis of chronic phase Philadelphia chromosome-positive chronic myelogenous leukemia
- b) Diagnosis of accelerated phase or blast phase Philadelphia chromosome-positive chronic myelogenous leukemia AND documented resistance or intolerance to prior therapy (e.g., imatinib)

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**Braftovi (encorafenib)**

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The plan may authorize coverage of Braftovi (encorafenib) for Members when **ALL** of the following criteria are met:

**Colorectal Cancer**

1. Documented diagnosis of metastatic colorectal cancer

**AND**

2. Documentation of BRAF V600E mutation as detected by an FDA approved test

**AND**

3. The prescribing physician is an oncologist

**AND**

4. Documentation of use in combination with Erbitux (cetuximab)

**AND**

5. Documentation the Member has received prior therapy for the treatment of colorectal cancer

#### **Melanoma**

1. Documented diagnosis of unresectable or metastatic melanoma  
**AND**
2. Documentation of BRAF V600E or V600K mutation as detected by an FDA approved test  
**AND**
3. The prescribing physician is an oncologist  
**AND**
4. Documentation of use in combination with Mektovi (binimetinib)

#### **Non-small Cell Lung Cancer**

1. Documented diagnosis of metastatic non-small cell lung cancer  
**AND**
2. Documentation of BRAF V600E mutation as detected by an FDA approved test  
**AND**
3. The prescribing physician is an oncologist  
**AND**
4. Documentation of use in combination with Mektovi (binimetinib)

#### **Brukina (zanubrutinib)**

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The plan may authorize coverage of Brukina (zanubrutinib) for Members when **ALL** of the following criteria are met:

##### **Chronic Lymphocytic Leukemia or Small Lymphocytic Leukemia**

1. Documented diagnosis of chronic lymphocytic leukemia or small lymphocytic leukemia  
**AND**
2. The prescribing physician is an oncologist or hematologist

##### **Mantle Cell Lymphoma**

1. Documented diagnosis of mantle cell lymphoma  
**AND**
2. Documentation the Member has received at least one prior therapy  
**AND**
3. The prescribing physician is an oncologist or hematologist

##### **Marginal Zone Lymphoma**

1. Documented diagnosis of marginal zone lymphoma  
**AND**
2. Documentation the Member has received at least one prior anti-CD20-based regimen  
**AND**
3. The prescribing physician is an oncologist or hematologist

##### **Waldenstrom's Macroglobulinemia**

1. Documented diagnosis of Waldenstrom's macroglobulinemia  
**AND**
2. The prescribing physician is an oncologist or hematologist

#### **Cabometyx (cabozantinib)**

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The plan may authorize coverage of Cabometyx (cabozantinib) for Members when **ALL** of the following criteria are met:

##### **Differentiated Thyroid Cancer**

1. Documented diagnosis of locally advanced or metastatic differentiated thyroid cancer  
**AND**
2. Documentation of disease progression following prior VEGFR-targeted therapy  
**AND**

3. Documentation the Member is refractory to or ineligible for radioactive iodine
- AND**

4. The prescribing physician is an oncologist

#### **Hepatocellular Carcinoma**

1. Documented diagnosis of hepatocellular carcinoma

**AND**

2. Documentation of previous treatment with sorafenib

**AND**

3. The prescribing physician is an oncologist

#### **Renal Cell Carcinoma**

1. Documented diagnosis of renal cell carcinoma

**AND**

2. The prescribing physician is an oncologist

#### **Calquence (acalabrutinib)**

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The plan may authorize coverage of Calquence (acalabrutinib) for Members, when **ALL** of the following criteria are met:

1. The prescribing physician is an oncologist or hematologist

**AND**

2. Documentation of one of the following:

- a. Diagnosis of mantle cell lymphoma AND the Member has received at least one prior therapy
- b. Diagnosis of chronic lymphocytic leukemia
- c. Diagnosis of small lymphocytic lymphoma

**AND**

3. If the diagnosis is mantle cell lymphoma, documentation of one (1) of the following:

- a. The patient has received at least one (1) prior therapy
- b. Documentation of both of the following:
  - i. The patient is previously untreated and ineligible for autologous hematopoietic stem cell transplantation
  - ii. The requested medication will be used in combination with bendamustine and rituximab

#### **Caprelsa (vandetanib)**

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The plan may authorize coverage of Caprelsa (vandetanib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of symptomatic or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease

**AND**

2. The prescribing physician is an oncologist

#### **Cometriq (cabozantinib)**

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The plan may authorize coverage of Cometriq (cabozantinib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of progressive, metastatic medullary thyroid cancer

**AND**

2. The prescribing physician is an oncologist

#### **Copiktra (duvelisib)**

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The plan may authorize coverage of Copiktra (duvelisib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of one of the following:
  - a) Relapsed or refractory chronic lymphocytic leukemia
  - b) Relapsed or refractory small lymphocytic lymphoma

**AND**

2. Documentation the Member has received at least two prior systemic therapies

**AND**

3. The prescribing physician is an oncologist or hematologist

#### **Cotellic (cobimetinib)**

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The plan may authorize coverage of Cotellic (cobimetinib) for Members, when **ALL** the following criteria are met:

1. Documented diagnosis of unresectable or metastatic melanoma

**AND**

2. The prescribing physician is an oncologist

**AND**

3. The Member has BRAF V600E or V600K mutation-positive melanoma as detected by an FDA-approved test

**AND**

4. Documentation that Cotellic (cobimetinib) will be administered in combination with Zelboraf (vemurafenib)

#### **Daurismo (glasdegib)**

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The plan may authorize coverage of Daurismo (glasdegib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of acute myeloid leukemia

**AND**

2. Documentation Daurismo will be administered in combination with low-dose cytarabine

**AND**

3. The prescribing physician is an oncologist or hematologist

**AND**

4. Documentation of one of the following:

- a) Member is at least 75 years old

- b) Member has a comorbidity that precludes the use of intensive induction chemotherapy

#### **Erivedge (vismodegib)**

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The plan may authorize coverage of Erivedge (vismodegib) for Members, when **ALL** of the following criteria are met:

1. Documentation of one of the following:

- a) Diagnosis of metastatic basal cell carcinoma

- b) Diagnosis of locally advanced basal cell carcinoma AND that disease has recurred following surgery or the Member is not a candidate for surgery or radiation therapy

**AND**

2. The prescribing physician is an oncologist

#### **Everolimus tablet**

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The plan may authorize coverage of **Everolimus tablets** for Members, when **ALL** of the following criteria are met:

##### **Advanced Renal Cell Carcinoma**

1. Documented diagnosis of advanced renal cell carcinoma

**AND**

2. The prescribing physician is an oncologist

**AND**

3. The patient has a demonstrated disease progression or intolerance following an appropriate trial with sunitinib or sorafenib

##### **Subependymal Giant Cell Astrocytoma (SEGA)**

1. Documented diagnosis of subependymal giant cell astrocytoma associated with tuberous sclerosis complex

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Documentation the Member is not a candidate for surgical resection

**Progressive Neuroendocrine Tumors**

1. Documentation of at least one of the following:

- a) Diagnosis of progressive neuroendocrine tumor located in the pancreas
- b) Diagnosis of progressive, well-differentiated, non-functional neuroendocrine tumor located in the gastrointestinal tract or lung

**AND**

2. The prescribing physician is an oncologist

**AND**

3. The tumor cannot be removed by surgery or has spread to other parts of the body

**Renal Angiomyolipoma with Tuberous Sclerosis Complex**

1. Documented presence of tuberous sclerosis and renal angiomyolipoma(s) greater than or equal to 3 cm in longest diameter

**AND**

2. The prescribing physician is an oncologist

**Advanced Hormone Receptor-Positive, HER2-Negative Breast Cancer (Advanced HR+ BC)**

1. Documented diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer

**AND**

2. The Member is postmenopausal

**AND**

3. The prescribing physician is an oncologist

**AND**

4. Documented failure of letrozole or anastrozole

**AND**

5. Documentation that the requested agent will be administered in combination with exemestane

**Tuberous Sclerosis Complex-Associated Partial-Onset Seizures**

1. Documented diagnosis of partial-onset seizures associated with tuberous sclerosis complex

**AND**

2. Documentation of use as adjunctive therapy in combination with other therapies (e.g., anticonvulsants)

**AND**

3. The Member is at least 2 years of age or older

**AND**

4. The prescribing physician is an oncologist or a neurologist

**Everolimus tablets for oral suspension**

The plan may authorize coverage of **everolimus tablets for oral suspension** for Members when **ALL** of the following criteria are met:

**Subependymal Giant Cell Astrocytoma (SEGA)**

1. Documented diagnosis of subependymal giant cell astrocytoma associated with tuberous sclerosis complex

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Member is not a candidate for surgical resection

**Tuberous Sclerosis Complex-Associated Partial-Onset Seizures**

1. Documented diagnosis of partial-onset seizures associated with tuberous sclerosis complex

**AND**

2. Documentation of use as adjunctive therapy in combination with other therapies (e.g., anticonvulsants)

**AND**

3. The Member is at least 2 years of age or older

**AND**

4. The prescribing physician is an oncologist or a neurologist

#### **Exkivity (mobocertinib)**

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The plan may authorize coverage of Exkivity (mobocertinib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of locally advanced or metastatic non-small cell lung cancer

**AND**

2. Documentation of epidermal growth factor receptor exon 20 insertion mutation as detected by an FDA approved test

**AND**

3. Documentation the Member has previously received platinum-based chemotherapy

**AND**

4. The prescribing physician is an oncologist

#### **Farydak (panobinostat)**

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The plan may authorize coverage of Farydak (panobinostat) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of multiple myeloma

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Documentation the Member has received at least two prior therapies, including bortezomib and an immunomodulatory agent

**AND**

4. Documentation the Member will be receiving both bortezomib and dexamethasone in conjunction with panobinostat

#### **Fotivda (tivozanib)**

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The plan may authorize coverage of Fotivda (tivozanib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of relapsed or refractory advanced renal cell carcinoma

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Documentation the member has received at least two prior systemic therapies

#### **Fruzaqla (fruquintinib)**

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The plan may authorize coverage of Fruzaqla (fruquintinib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of metastatic colorectal cancer

**AND**

2. Documentation the patient has received treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy

**AND**

3. Documentation the patient has received treatment with anti-VEGF therapy

**AND**

4. If RAS wild-type, documentation of **one (1)** of the following:
  - a. The patient has received treatment with anti-EGFR therapy



- b. Anti-EGFR therapy is not medically appropriate

**AND**

- 5. The prescribing physician is an oncologist

#### **Gavreto (pralsetinib)**

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The plan may authorize coverage of Gavreto (pralsetinib) for Members, when **ALL** of the following criteria are met:

##### **Non-small Cell Lung Cancer**

- 1. Documented diagnosis of metastatic non-small cell lung cancer

**AND**

- 2. Documentation of RET fusion-positive cancer

**AND**

- 3. The Member is at least 18 years of age or older

**AND**

- 4. The prescribing physician is an oncologist

##### **Thyroid Cancer**

- 1. Documented diagnosis of advanced or metastatic thyroid cancer

**AND**

- 2. Documentation of RET fusion-positive cancer

**AND**

- 3. Documentation the patient requires systemic therapy

**AND**

- 4. Documentation of **one (1)** of the following:

- a. The patient is radioactive iodine-refractory
- b. Radioactive iodine is not clinically appropriate

**AND**

- 5. The patient is at least 12 years of age or older

**AND**

- 6. The prescribing physician is an oncologist

#### **Gilotrif (afatinib)**

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The plan may authorize coverage of Gilotrif (afatinib) for Members when **ALL** of the following criteria are met:

- 1. The prescribing physician is an oncologist

**AND**

- 2. Documentation of one of the following:

- a) Documented diagnosis of metastatic non-small cell lung cancer with tumors that have non-resistant epidermal growth factor receptor mutations as detected by an FDA-approved test
- b) Documented diagnosis of metastatic, squamous non-small cell lung cancer progressing after platinum-based chemotherapy

#### **Hycamtin (topotecan)**

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The plan may authorize coverage of Hycamtin (topotecan) capsules for Members, when **ALL** of the following criteria are met:

- 1. Documented diagnosis of relapsed small cell lung cancer in patients with a prior complete or partial response and who are at least 45 days from the end of first-line chemotherapy

**AND**

- 2. The prescribing physician is an oncologist

### **Ibrance (palbociclib)**

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The plan may authorize coverage of Ibrance (palbociclib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of hormone receptor positive, human epidermal growth factor receptor-2 negative advanced metastatic breast cancer

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Documentation of use in combination with one of the following:
  - a) An aromatase inhibitor as initial endocrine-based therapy in postmenopausal women or men
  - b) Fulvestrant in patients with disease progression following endocrine therapy

### **Iclusig (ponatinib)**

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The plan may authorize coverage of Iclusig (ponatinib) for Members, when **ALL** the following criteria are met:

#### **Acute Lymphoblastic Leukemia**

1. The prescribing physician is an oncologist or hematologist

**AND**

2. Documented diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia

**AND**

3. Documentation of **one (1)** of the following:
  - a) Patient is newly diagnosed and Iclusig will be used in combination with chemotherapy
  - b) No other kinase inhibitor is indicated or T315I-positive disease and Iclusig will be used as monotherapy

#### **Chronic Myeloid Leukemia**

1. The prescribing physician is an oncologist or hematologist

**AND**

2. Documented diagnosis of chronic myeloid leukemia

**AND**

3. Documentation of one of the following:
  - a) Chronic phase chronic myeloid leukemia with resistance or intolerance to at least two prior kinase inhibitors
  - b) Accelerated phase or blast phase chronic myeloid leukemia for whom no other kinase inhibitors are indicated
  - c) T315I-positive chronic myeloid leukemia (chronic phase, accelerated phase, or blast phase)

### **Idhifa (enasidenib)**

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The plan may authorize coverage of Idhifa (enasidenib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of isocitrate dehydrogenase-2 mutated acute myeloid leukemia (as detected by an FDA-approved test)

**AND**

2. Documentation of at least one prior anticancer regimen for the treatment of acute myeloid leukemia

**AND**

3. Prescribing physician is an oncologist or hematologist

### **Imbruvica (ibrutinib)**

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The plan may authorize coverage of Imbruvica (ibrutinib) for Members, when **ALL** of the following criteria are met:

#### **Mantle cell lymphoma**

1. Documented diagnosis of mantle cell lymphoma

**AND**

2. The prescribing physician is an oncologist or hematologist

**AND**

3. The Member has been treated with at least one prior therapy

**Chronic lymphocytic leukemia and small lymphocytic lymphoma with or without 17p deletion**

1. The Member has a diagnosis of chronic lymphocytic leukemia or small lymphocytic lymphoma with or without 17p deletion

**AND**

2. The prescribing physician is an oncologist or hematologist

**Waldenstrom's macroglobulinemia**

1. Documented diagnosis of Waldenstrom's macroglobulinemia

**AND**

2. The prescribing physician is an oncologist or hematologist

**Marginal Zone Lymphoma**

1. Documented diagnosis of marginal zone lymphoma with required systemic therapy

**AND**

2. The Member has been treated with at least one prior anti-CD20-based therapy

**AND**

3. The prescribing physician is an oncologist or hematologist

**Chronic Graft versus Host Disease**

1. Documented diagnosis of chronic graft versus host disease

**AND**

2. The Member has been treated with at least one systemic therapy (e.g., corticosteroids)

**Inlyta (axitinib)**

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The plan may authorize coverage of Inlyta (axitinib) for Members, when the following criteria are met:

1. Documented diagnosis of advanced renal cell carcinoma

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Documentation of one of the following:

- a. Use in combination with avelumab or pembrolizumab
- b. Failure of at least one prior first-line systemic therapy (e.g. Sutent, Nexavar, Afinitor, Votrient, Avastin, Torisel)

**Inrebic (fedratinib)**

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The plan may authorize coverage of Inrebic (fedratinib) for Members when the following criteria are met:

1. Documented diagnosis of intermediate-2 or high-risk, primary or secondary myelofibrosis

**AND**

2. The prescribing physician is an oncologist or hematologist

**Inqovi (decitabine and cedazuridine)**

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The plan may authorize coverage of Inqovi (decitabine and cedazuridine) for Members, when the following criteria are met:

1. Documented diagnosis of myelodysplastic syndromes

**AND**

2. The prescribing physician is an oncologist or hematologist

**AND**

3. Documentation the Member is not administering Inqovi concomitantly with intravenous decitabine

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**Iressa (gefitinib)**

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The plan may authorize coverage for Iressa (gefitinib) when **ALL** of the following criteria are met:

1. Documented diagnosis of metastatic non-small cell lung cancer whose tumors have epidermal growth factor exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test

**AND**

2. The prescribing physician is an oncologist

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**Itovebi (inavolisib)**

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The plan may authorize coverage for Itovebi (inavolisib) when **ALL** of the following criteria are met:

1. Documented diagnosis of endocrine-resistant, PIK3CA-mutated, hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, locally advanced or metastatic breast cancer, as detected by an FDA-approved test

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Documentation the requested medication will be used in combination with palbociclib and fulvestrant

**AND**

4. Documentation of disease recurrence on or after completing adjuvant endocrine therapy

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**Iwilfin (eflornithine)**

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The plan may authorize coverage for Iwilfin (eflornithine) when **ALL** of the following criteria are met:

1. Documented diagnosis of high-risk neuroblastoma

**AND**

2. Documentation the patient has had at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy

**AND**

3. Documentation Iwilfin will be used as a single agent

**AND**

4. The prescribing physician is an oncologist

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**Jakafi (ruxolitinib)**

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The plan may authorize coverage of Jakafi (ruxolitinib) for Members, when **ALL** the following criteria are met:

**Graft-Versus-Host Disease**

1. Documentation of **one (1)** of the following:
  - a. Steroid-refractory acute graft-versus-host disease
  - b. Chronic graft-versus-host disease AND failure with at least one prior line of systemic therapy (e.g., corticosteroids)

**AND**

2. Member is at least 12 years of age or older

**Myelofibrosis**

1. Documented diagnosis of intermediate or high-risk myelofibrosis

**Polycythemia Vera**

1. Documented diagnosis of polycythemia

**AND**

2. Documented inadequate response or intolerance to hydroxyurea

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**Jaypirca (pirtobrutinib)**

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The plan may authorize coverage of Jaypirca (pirtobrutinib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of relapsed or refractory mantle cell lymphoma

**AND**

2. The prescribing physician is an oncologist or hematologist

**AND**

3. Documentation the Member has received at least two prior lines of systemic therapies

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**Kisqali (ribociclib)**

The plan may authorize coverage of Kisqali (ribociclib) for Members, when **ALL** of the following criteria are met:

**Advanced or Metastatic Breast Cancer**

1. Documented diagnosis of advanced or metastatic breast cancer

**AND**

2. Documentation the disease meets **ALL** of the following:
  - a) Hormone receptor positive
  - b) Human epidermal growth factor receptor 2 (HER 2) negative

**AND**

3. The prescribing physician is an oncologist

**AND**

4. Documentation of one of the following:
  - a) Use in combination with an aromatase inhibitor as initial endocrine-based therapy
  - b) Use in combination with fulvestrant as initial endocrine-based therapy or following disease progression on endocrine therapy in a postmenopausal woman

**Early Breast Cancer**

1. Documented diagnosis of early breast cancer at high risk of recurrence

**AND**

2. Documentation the disease meets all of the following:
  - a. Hormone receptor positive
  - b. Human epidermal growth factor receptor 2 (HER 2) negative

**AND**

3. The prescribing physician is an oncologist

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**Koselugo (selumetinib)**

The plan may authorize coverage of Koselugo (selumetinib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of neurofibromatosis type 1

**AND**

2. Documentation of symptomatic, inoperable plexiform neurofibromas

**AND**

3. The Member is at least 2 years of age or older

**AND**

4. The prescribing physician is an oncologist, geneticist, or neurologist

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**Krazati (adagrasib)**

1. Documented diagnosis of locally advanced or metastatic non-small cell lung cancer

**AND**

2. Documentation cancer is KRAS G12C-mutation positive as detected by a Food and Drug Administration-approved test

**AND**

3. The prescribing physician is an oncologist

**AND**

4. Documentation the patient has received at least **one** (1) prior systemic therapy

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**Lazcluze (lazertinib)**

The plan may authorize coverage of Lazcluze (lazertinib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of locally advanced or metastatic non-small cell lung cancer  
**AND**
2. Documentation of an epidermal growth factor receptor exon 19 deletion or exon 21 L858R substitution mutation as detected by a Food and Drug Administration-approved test  
**AND**
3. Documentation of use in combination with Rybrevant  
**AND**
4. The prescribing physician is an oncologist

#### **Lenvima (lenvatinib)**

The plan may authorize coverage of Lenvima (lenvatinib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of one of the following:
  - a) Locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer
  - b) Use in combination with everolimus for advanced renal cell carcinoma following one prior anti-angiogenic therapy
  - c) Unresectable hepatocellular carcinoma
  - d) Use in combination with pembrolizumab for advanced endometrial carcinoma that is not microsatellite instability-high or mismatch repair deficient AND disease progression following systemic therapy AND documentation the Member is not a candidate for curative surgery or radiation
- AND**
2. The prescribing physician is an oncologist

#### **Lonsurf (trifluridine/tipiracil)**

The plan may authorize coverage for Lonsurf (trifluridine/tipiracil) when **ALL** of the following criteria are met:

1. The prescribing physician is an oncologist  
**AND**
2. Documentation of one of the following
  - a) Documented diagnosis of metastatic colorectal cancer (mCRC) AND Documentation the Member has been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy; an anti-vascular endothelial growth factor (VEGF) biological therapy; and if rat sarcoma viral oncogene (RAS) wild-type, an anti-epidermal growth factor receptor (EGFR) therapy
  - b) Documented diagnosis of metastatic gastric or gastroesophageal junction adenocarcinoma AND Documentation the Member has been previously treated with at least two prior lines of chemotherapy that included fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate, HER2/neu-targeted therapy

#### **Lorbrena (lorlatinib)**

The plan may authorize coverage for Lorbrena (lorlatinib) when **ALL** of the following criteria are met:

1. Documented diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer as detected by a Food and Drug Administration-approved test  
**AND**
2. The prescribing physician is an oncologist

#### **Lumakras (sotorasib)**

The plan may authorize coverage for Lumakras (sotorasib) when **ALL** of the following criteria are met:

1. Documented diagnosis of locally advanced or metastatic non-small cell lung cancer  
**AND**
2. Documentation cancer is KRAS G12C-mutation positive as detected by an FDA-approved test  
**AND**
3. Documentation the prescribing physician is an oncologist  
**AND**

4. Documentation the Member has received at least one prior systemic therapy

### **Lynparza (olaparib)**

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The plan may authorize coverage of Lynparza (olaparib) for Members, when **ALL** of the following criteria are met:

#### **Breast Cancer**

1. The prescribing physician is an oncologist

**AND**

2. Documented diagnosis of **one (1)** of the following based on an FDA-approved test:
  - a. Deleterious or suspected deleterious germline BRCA-mutated, HER2-negative metastatic breast cancer
  - b. Deleterious or suspected deleterious germline BRCA-mutated, HER2-negative high risk early breast cancer

**AND**

3. Documentation the Member has received chemotherapy in the neoadjuvant, adjuvant, or metastatic setting

**AND**

4. In patients with hormone receptor positive breast cancer, documentation of one of the following:
  - a) The Member has previous treatment with an endocrine therapy
  - b) The Member is considered inappropriate for endocrine therapy

#### **Ovarian Cancer**

1. The prescribing physician is an oncologist or gynecologist with oncologist training

**AND**

2. Documentation of one of the following:
  - a) Diagnosis of recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer AND Member is in complete or partial response to platinum-based chemotherapy
  - b) Diagnosis of deleterious or suspected deleterious germline or somatic BRCA mutated advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer as detected by an FDA approved test (germline BRCA mutated only) AND Member is in complete or partial response to first-line platinum based chemotherapy
  - c) Diagnosis of deleterious or suspected deleterious germline BRCA mutated advanced ovarian cancer as detected by an FDA approved test AND Member has tried and failed at least three prior lines of chemotherapy
  - d) Diagnosis of advanced epithelial ovarian, fallopian tube or primary peritoneal cancer who are in complete or partial response to first-line platinum-based chemotherapy and whose cancer is associated with homologous recombination deficiency-positive status AND documentation of use in combination with bevacizumab

#### **Pancreatic Cancer**

1. The prescribing physician is an oncologist

**AND**

2. Documented diagnosis of deleterious or suspected deleterious germline BRCA-mutated metastatic pancreatic adenocarcinoma as detected by an FDA approved test

**AND**

3. Documentation of no disease progression after at least 16 weeks of first-line platinum-based chemotherapy

#### **Prostate Cancer**

1. Documented diagnosis of metastatic castration-resistant prostate cancer

**AND**

2. Documentation of **one (1)** of the following:
  - a. Both of the following:
    - i. Deleterious or suspected deleterious germline or somatic homologous recombination repair gene-mutated cancer

- ii. The Member has progressed following prior treatment with enzalutamide or abiraterone
- b. Both of the following:
  - i. Deleterious or suspected deleterious BRCA-mutated cancer
- c. Use in combination with abiraterone and prednisone or prednisolone

**AND**

- 3. The prescribing physician is an oncologist

### **Lytgobi (futibatinib)**

The plan may authorize coverage of Lytgobi (futibatinib) for Members, when **ALL** of the following criteria are met:

- 1. Documented diagnosis of unresectable, locally advanced or metastatic intrahepatic cholangiocarcinoma

**AND**

- 2. Documentation the cancer has a fibroblast growth factor receptor 2 fusion or other rearrangements

**AND**

- 3. The prescribing physician is an oncologist

**AND**

- 4. Documentation the Member has received a previous treatment for the requested condition

### **Mekinist (trametinib)**

The plan may authorize coverage of Mekinist (trametinib) for Members when **ALL** of the following criteria are met:

- 1. The prescribing physician is an oncologist

**AND**

- 2. Documentation of one of the following:

- a) Diagnosis of metastatic non-small cell lung cancer with BRAF V600E mutation as detected by an FDA-approved test
- b) Diagnosis of unresectable or metastatic melanoma with BRAF V600E or V600K mutation as detected by an FDA-approved test
- c) Diagnosis of locally advanced or metastatic anaplastic thyroid cancer with BRAF V600E mutation AND locoregional treatment options are not appropriate
- d) Use as adjuvant treatment following complete resection for a diagnosis of melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test AND lymph node involvement
- e) Diagnosis of unresectable or metastatic solid tumors with BRAF V600E mutation AND disease progression following prior treatment AND no satisfactory alternative treatment options
- f) Diagnosis of low-grade glioma with BRAF V600E mutation AND the patient requires systemic therapy

### **Mektovi (binimetinib)**

The plan may authorize coverage of Mektovi (binimetinib) for Members when **ALL** of the following criteria are met:

#### **Melanoma**

- 1. Documented diagnosis of unresectable or metastatic melanoma

**AND**

- 2. Documentation of BRAF V600E or V600K mutation as detected by an FDA approved test

**AND**

- 3. The prescribing physician is an oncologist

**AND**

- 4. Documentation of use in combination with Braftovi (encorafenib)

#### **Non-small Cell Lung Cancer**

- 1. Documented diagnosis of metastatic non-small cell lung cancer

**AND**



2. Documentation of BRAF V600E mutation as detected by an FDA approved test

**AND**

3. The prescribing physician is an oncologist

**AND**

4. Documentation of use in combination with Braftovi (encorafenib)

### **Nerlynx (neratinib)**

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The plan may authorize coverage of Nerlynx (neratinib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of human epidermal growth factor receptor 2-positive breast cancer

**AND**

2. Documentation of one of the following:

- a. Early-stage disease AND use following trastuzumab therapy
- b. Advanced or metastatic disease AND use in combination with capecitabine following at least two prior anti-human epidermal growth factor receptor 2 based regimens

**AND**

3. Prescribing physician is an oncologist

### **Nexavar (sorafenib)**

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The plan may authorize coverage of Nexavar (sorafenib) when **ALL** of the following criteria are met:

#### **Advanced Renal Cell Carcinoma (RCC)**

1. The Member is at least 18 years of age or older

**AND**

2. Documented diagnosis of advanced renal cell carcinoma

**AND**

3. The prescribing physician is an oncologist

#### **Unresectable Hepatocellular Carcinoma (HCC)**

1. The Member is at least 18 years of age or older

**AND**

2. Documented diagnosis of biopsy-proven, unresectable hepatocellular carcinoma

**AND**

3. The prescribing physician is an oncologist

#### **Differentiated Thyroid Carcinoma**

1. The Member is at least 18 years of age or older

**AND**

2. Documented diagnosis of locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment

**AND**

3. The prescribing physician is an oncologist or Thyroid Specialist

### **Ninlaro (ixazomib)**

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The plan may authorize coverage of Ninlaro (ixazomib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of multiple myeloma

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Documentation the Member has received at least one prior therapy

**AND**

4. Documentation that Ninlaro (ixazomib) will be administered in combination with lenalidomide and dexamethasone

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**Odomzo (sonidegib)**

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The plan may authorize coverage of Odomzo (sonidegib) for Members when the following criteria are met:

1. Documented diagnosis of locally advanced basal cell carcinoma  
**AND**
2. The prescribing physician is an oncologist  
**AND**
3. Documentation of one of the following:
  - a) Documentation of disease recurrence following surgery or radiation therapy
  - b) Documentation the Member is not a candidate for surgery or radiation therapy

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**Ogsiveo (nirogacestat)**

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The plan may authorize coverage of Ogsiveo (nirogacestat) for Members when the following criteria are met:

1. Documented diagnosis of a desmoid tumor  
**AND**
2. Patient is at least 18 years of age or older  
**AND**
3. The prescribing physician is an oncologist or a sarcoma specialist  
**AND**
4. Documentation of **one (1)** of the following:
  - a. Persistent disease progression (e.g., evidence of disease progression at more than one assessment)
  - b. Increase of symptoms of burden

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**Ojemda (tovoraenib)**

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The plan may authorize coverage of Ojemda (tovoraenib) for Members when the following criteria are met:

1. Documented diagnosis of relapsed or refractory pediatric low-grade glioma  
**AND**
2. Documentation of a BRAF fusion or rearrangement, or BRAF V600 mutation  
**AND**
3. The prescribing physician is an oncologist

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**Ojjaara (momeotinib)**

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The plan may authorize coverage of Ojjaara (momeotinib) for Members when the following criteria are met:

4. Documented diagnosis intermediate or high-risk myelofibrosis  
**AND**
5. Documentation the patient has anemia defined as a measured hemoglobin level of less than or equal to 10 g/dL in previous 30 days  
**AND**
6. The prescribing physician is an oncologist or hematologist

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**Onureg (azacitidine)**

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The plan may authorize coverage of Onureg (azacitidine) for Members when the following criteria are met:

1. Documented diagnosis of acute myeloid leukemia  
**AND**
2. Documentation the Member has achieved first complete remission or complete remission with incomplete blood count recovery following intensive induction chemotherapy  
**AND**
3. Documentation the Member is unable to complete intensive curative therapy (e.g., stem cell transplant)

**AND**

4. The prescribing physician is an oncologist or hematologist

#### **Orgovyx (relugolix)**

---

The plan may authorize coverage of Orgovyx (relugolix) for Members when the following criteria are met:

1. Documented diagnosis of advanced prostate cancer as defined by **one (1) of the following**:
  - a. Evidence of biochemical (i.e., prostate-specific antigen) or clinical relapse following local primary intervention with curative intent (e.g., surgery, radiation therapy, cryotherapy, or high-frequency ultrasound) and not a candidate for salvage treatment by surgery
  - b. Newly diagnosed androgen-sensitive metastatic disease
  - c. Advanced localized disease (Stage III; cancer has spread outside of the prostate but only to nearby tissues) unlikely to be cured by local primary intervention with either surgery or radiation with curative intent

**AND**

2. The prescribing physician is an oncologist or urologist

#### **Orserdu (elacestrant)**

---

The plan may authorize coverage of Orserdu (elacestrant) for Members when the following criteria are met:

1. Documentation diagnosis of estrogen receptor positive, HER2 negative advanced or metastatic breast cancer

**AND**

2. Documentation the Member has ESR1-mutated disease

**AND**

3. If female, documentation the Member is post-menopausal

**AND**

4. The prescribing physician is an oncologist

**AND**

5. Documentation the Member has disease progression following at least one line of endocrine therapy, which must include a CDK 4/6 inhibitor (e.g., Ibrance, Kisqali, Verzenio)

#### **Pemazyre (pemigatinib)**

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The plan may authorize coverage of Pemazyre (pemigatinib) for Members when the following criteria are met:

##### **Cholangiocarcinoma**

1. Documented diagnosis of unresectable locally advanced or metastatic cholangiocarcinoma

**AND**

2. Documentation of fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test

**AND**

3. Documentation the Member has received a previous treatment for the requested condition

**AND**

4. The prescribing physician is an oncologist

##### **Myeloid/Lymphoid Neoplasms**

1. Documented diagnosis of relapsed or refractory myeloid/lymphoid neoplasms

**AND**

2. Documentation of fibroblast growth factor receptor 1 (FGFR1) rearrangement

**AND**

3. The prescribing physician is an oncologist

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**Piqray (alpelisib)**

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The plan may authorize coverage of Piqray (alpelisib) for Members when the following criteria are met:

1. Documented diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, advanced or metastatic breast cancer

**AND**

2. Documentation of PIK3CA-mutated disease as detected by an FDA-approved test

**AND**

3. Documentation of disease progression on or after an endocrine-based regimen

**AND**

4. The prescribing physician is an oncologist

**AND**

5. Documentation Piqray will be used in combination with fulvestrant

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**Pomalyst (pomalidomide)**

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The plan may authorize coverage of Pomalyst (pomalidomide) for Members, when **ALL** of the following criteria are met:

**Kaposi Sarcoma**

1. Documentation of one of the following:

- a. Diagnosis of Kaposi sarcoma and HIV-negative status
- b. Diagnosis of AIDS-related Kaposi sarcoma after failure of highly active antiretroviral therapy

**AND**

2. The prescribing physician is an oncologist

**Multiple Myeloma**

1. Documented diagnosis of multiple myeloma

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Documentation the Member has failed two prior therapies, including bortezomib and lenalidomide

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**Qinlock (ripretinib)**

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The plan may authorize coverage of Qinlock (ripretinib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of advanced gastrointestinal stromal tumor

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Documentation the Member has previously received treatment with imatinib and at least two other kinase inhibitors

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**Retevmo (selpercatinib)**

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The plan may authorize coverage of Retevmo (selpercatinib) for Members when **ALL** of the following criteria are met:

**Non-small Cell Lung Cancer**

1. Documented diagnosis of metastatic non-small cell lung cancer

**AND**

2. Documentation of RET fusion-positive cancer

**AND**

3. The Member is at least 18 years of age or older

**AND**

4. The prescribing physician is an oncologist

**Medullary Thyroid Cancer**

1. Documented diagnosis of advanced or metastatic medullary thyroid cancer

- AND**
- 2. Documentation of RET-mutant cancer
- AND**
- 3. Documentation the Member requires systemic therapy
- AND**
- 4. The Member is at least 2 years of age or older
- AND**
- 5. The prescribing physician is an oncologist

#### **Thyroid Cancer**

- 1. Documented diagnosis of advanced or metastatic thyroid cancer
- AND**
- 2. Documentation of RET fusion-positive cancer
- AND**
- 3. Documentation the Member requires systemic therapy
- AND**
- 4. Documentation of one of the following:
  - a. The Member is radioactive iodine-refractory
  - b. Radioactive iodine is not clinically appropriate
- AND**
- 5. The Member is at least 2 years of age or older
- AND**
- 6. The prescribing physician is an oncologist

#### **RET Fusion-positive Solid Tumors**

- 1. Documented diagnosis of locally advanced or metastatic solid tumors
- AND**
- 2. Documentation of RET gene fusion-positive cancer
- AND**
- 3. The Member is at least 2 years of age or older
- AND**
- 4. The prescribing physician is an oncologist
- AND**
- 5. Documentation of **one (1)** of the following:
  - a. Progression on or following prior systemic treatment
  - b. No satisfactory alternative treatment options

#### **Revlimid (lenalidomide)**

The plan may authorize coverage of Revlimid (lenalidomide) for Members when **ALL** of the following criteria are met:

#### **Transfusion-dependent Anemia**

- 1. Documented diagnosis of transfusion dependent anemia due to myelodysplastic syndrome associated with the 5q-deletion cytogenetic abnormality
- AND**
- 2. The prescribing physician is an oncologist or hematologist

#### **Multiple Myeloma**

- 1. Documentation of one of the following:
  - a) Diagnosis of multiple myeloma AND use in combination with dexamethasone
  - b) Use as maintenance therapy in a Member following autologous hematopoietic stem cell transplantation
- AND**
- 2. The prescribing physician is an oncologist or hematologist

**Mantle Cell Lymphoma**

1. Documented diagnosis of mantle cell lymphoma  
**AND**
2. Documentation the Member's disease has relapsed or progressed after two prior therapies, one of which included Velcade (bortezomib)  
**AND**
3. The prescribing physician is an oncologist or hematologist

**Follicular Lymphoma**

1. Documented diagnosis of follicular lymphoma  
**AND**
2. Documentation the Member has been previously treated  
**AND**
3. The prescribing physician is an oncologist or hematologist  
**AND**
4. Revlimid will be used in combination with a rituximab product

**Marginal Zone Lymphoma**

1. Documented diagnosis of marginal zone lymphoma  
**AND**
2. Documentation the Member has been previously treated  
**AND**
3. The prescribing physician is an oncologist or hematologist  
**AND**
4. Revlimid will be used in combination with a rituximab product

**Revuforj (revumenib)**

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1. Documented diagnosis of relapsed or refractory acute myeloid leukemia  
**AND**
2. Documentation of a lysine methyltransferase 2A gene (KMT2A) translocation  
**AND**
3. The prescribing physician is an oncologist or hematologist

**Rezlidhia (olutasidenib)**

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1. Documented diagnosis of relapsed or refractory acute myeloid leukemia  
**AND**
2. Documentation cancer has susceptible IDH1 mutation as detected by a Food and Drug Administration-approved test  
**AND**
3. The prescribing physician is an oncologist or hematologist

**Rozlytrek (entrectinib)**

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The plan may authorize coverage of Rozlytrek (entrectinib) for Members, when all the following criteria are met:

1. The prescribing physician is an oncologist  
**AND**
2. Documentation of one of the following:
  - a. ROS1-positive, metastatic NSCLC
  - b. Solid tumor that have a NTRK gene fusion without a known resistance mutation **AND** the disease is metastatic or surgical resection is likely to result in severe morbidity **AND** the Member has progressed following treatment or has no satisfactory alternative therapy

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**Rubraca (rucaparib)**

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The plan may authorize coverage of Rubraca (rucaparib) for Members, when **ALL** the following criteria are met:

**Ovarian Cancer**

1. Documented diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer  
**AND**
2. Documentation of deleterious BRCA mutation associated cancer  
**AND**
3. Documentation the Member is in a complete or partial response to platinum-based chemotherapy  
**AND**
4. The prescribing physician is an oncologist or gynecologist with oncologist training

**Prostate Cancer**

1. Documented diagnosis metastatic castration-resistant prostate cancer  
**AND**
2. Documentation of deleterious BRCA mutation associated cancer as detected by a Food and Drug Administration-approved test  
**AND**
3. Documentation the Member has been previously treated with androgen receptor-directed therapy and a taxane-based chemotherapy  
**AND**
4. Documentation the prescribing physician is an oncologist

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**Rydapt (midostaurin)**

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The plan may authorize coverage of Rydapt (midostaurin) for Members, when **ALL** of the following criteria are met:

**Acute Myeloid Leukemia**

1. Documented diagnosis of FLT3 mutation-positive acute myeloid leukemia as detected by an FDA-approved test  
**AND**
2. Documentation requested use is in combination with cytarabine and daunorubicin induction and cytarabine consolidation  
**AND**
3. The prescribing physician is an oncologist or hematologist

**Other Hematologic Conditions**

1. Documented diagnosis of one of the following:
  - a) Aggressive systemic mastocytosis
  - b) Systemic mastocytosis with associated hematological neoplasm
  - c) Mast cell leukemia**AND**
3. The prescribing physician is an oncologist, hematologist, immunologist, or allergist

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**Scemblix (asciminib)**

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The plan may authorize coverage of Scemblix (asciminib) for Members, when **ALL** the following criteria are met:

1. Documented diagnosis of Philadelphia chromosome-positive chronic myeloid leukemia (CML)  
**AND**
2. Documentation from the prescribing physician that the member has chronic phase CML  
**AND**
3. Documentation of **one (1)** of the following:
  - a) T315I mutation
  - b) Previous treatment with at least two other tyrosine kinase inhibitors**AND**

4. The prescribing physician is an oncologist or hematologist

#### **Sprycel (dasatinib)**

---

The plan may authorize coverage of Sprycel (dasatinib) for Members, when **ALL** of the following criteria are met:

##### **Chronic Myeloid Leukemia (CML)**

1. Documentation of at least one of the following:
  - a) Newly diagnosed Philadelphia chromosome-positive CML in chronic phase
  - b) Chronic, accelerated, or myeloid or lymphoid blast phase Philadelphia chromosome CML with documented resistance or intolerance to prior therapy, including imatinib
  - c) Pediatric patient with Philadelphia chromosome positive CML in chronic phase

**AND**

2. The prescribing physician is an oncologist or hematologist

##### **Acute Lymphoblastic Leukemia (ALL)**

1. Documented diagnosis of Philadelphia chromosome-positive ALL

**AND**

2. The prescribing physician is an oncologist or hematologist

#### **Stivarga (regorafenib)**

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The plan may authorize coverage of Stivarga (regorafenib) for Members, when **ALL** of the following criteria are met:

##### **Metastatic Colorectal Cancer**

1. The Member has a diagnosis of metastatic colorectal cancer

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Documented prior failure, contraindication, or intolerance to prior therapy with **ALL** of the following:
  - a) fluoropyrimidine-based chemotherapy
  - b) oxaliplatin-based chemotherapy
  - c) irinotecan-based chemotherapy
  - d) anti-vascular endothelial growth factor (VEGF) therapy (e.g., bevacizumab)
  - e) anti-EGFR therapy (e.g., panitumumab or cetuximab) if the Member has RAS wild-type mCRC

##### **Gastrointestinal Stromal Tumor (GIST)**

1. The Member has a diagnosis of gastrointestinal stromal tumor

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Documented prior failure, contraindication, or intolerance to prior therapy with **ALL** of the following:
  - a) imatinib mesylate
  - b) sunitinib malate

##### **Hepatocellular Carcinoma**

1. The Member has a diagnosis of hepatocellular carcinoma

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Documented prior failure, contraindication, or intolerance to prior therapy with sorafenib



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**Sutent (sunitinib)**

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The plan may authorize coverage of Sutent (sunitinib) for Members when **ALL** of the following criteria are met:

**Renal Cell Carcinoma**

1. Documented diagnosis of at least one of the following:
  - a) Advanced renal cell carcinoma
  - b) High risk of recurrent renal cell carcinoma following nephrectomy

**AND**

2. The prescribing physician is an oncologist

**Gastrointestinal Stromal Tumor**

1. Documented diagnosis of gastrointestinal stromal tumor

**AND**

2. The prescribing physician is an oncologist

**AND**

3. The Member has a demonstrated disease progression or intolerance following an appropriate trial with imatinib mesylate

**Progressive Neuroendocrine Tumors**

1. Documented diagnosis of progressive neuroendocrine tumor located in the pancreas

**AND**

2. The prescribing physician is an oncologist

**AND**

3. The tumor cannot be removed by surgery or has spread to other parts of the body

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**Tabrecta (capmatinib)**

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The plan may authorize coverage of Tabrecta (capmatinib) for Members when **ALL** of the following criteria are met:

1. Documented diagnosis of metastatic non-small cell lung cancer

**AND**

2. Documentation the tumors have a mutation that leads to MET exon 14 skipping as detected by an FDA approved test

**AND**

3. The prescribing physician is an oncologist

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**Tafinlar (dabrafenib)**

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The plan may authorize coverage of Tafinlar (dabrafenib) for Members when **ALL** of the following criteria are met:

1. The prescribing physician is an oncologist

**AND**

2. Documentation of one of the following:

- a. Diagnosis of metastatic non-small cell lung cancer with BRAF V600E mutation as detected by an FDA-approved test
- b. Diagnosis of unresectable or metastatic melanoma with BRAF V600E or V600K mutation as detected by an FDA-approved test
- c. Diagnosis of locally advanced or metastatic anaplastic thyroid cancer with BRAF V600E mutation AND locoregional treatment options are not appropriate
- d. Use as adjuvant treatment following complete resection for a diagnosis of melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test AND lymph node involvement
- e. Diagnosis of unresectable or metastatic solid tumors with BRAF V600E mutation AND disease progression following prior treatment AND no satisfactory alternative treatment options
- f. Diagnosis of low-grade glioma with a BRAF V600E mutation AND patient requires systemic therapy

### **Tagrisso (osimertinib)**

---

The plan may authorize coverage of Tagrisso (osimertinib) for Members when the following criteria are met:

1. Documented diagnosis of non-small cell lung cancer

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Documentation of one of the following:

- a. Use as adjuvant therapy after tumor resection in adult patients with non-small cell lung cancer whose tumors have epidermal growth factor receptor exon 19 deletions or exon 21 L858R, as detected by a Food and Drug Administration-approved test
- b. Use as first-line treatment of adult patients with metastatic disease whose tumors have epidermal growth factor receptor exon 19 deletions or exon 21 L858R mutations as detected by a Food and Drug Administration-approved test
- c. Use in metastatic epidermal growth factor receptor T790M mutation-positive disease as detected by a Food and Drug Administration-approved test, in patients whose disease has progressed on or after epidermal growth factor tyrosine kinase inhibitor therapy

### **Talzenna (talazoparib)**

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The plan may authorize coverage of Talzenna (talazoparib) for Members when the following criteria are met:

1. Documentation of **one (1)** of the following:

- a. Diagnosis of deleterious or suspected deleterious germline BRCA-mutated, HER2-negative locally advanced or metastatic breast cancer based on a Food and Drug Administration-approved test
- b. Both of the following:
  - i. Diagnosis of homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer
  - ii. Use in combination with enzalutamide

**AND**

2. The prescribing physician is an oncologist or urologist

### **Tasigna (nilotinib)**

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The plan may authorize coverage of Tasigna (nilotinib) for Members when the following criteria are met:

#### **Newly Diagnosed Philadelphia Chromosome Positive Chronic Myeloid Leukemia in Chronic Phase**

1. Documented diagnosis of Philadelphia chromosome positive chronic myeloid leukemia in chronic phase

**AND**

2. The prescribing physician is an oncologist

#### **Resistant or Intolerant Philadelphia Chromosome Positive Chronic Myeloid Leukemia in Chronic Phase and Accelerated Phase**

1. Documented diagnosis of Philadelphia chromosome positive chronic myelogenous leukemia in chronic phase or in accelerated phase

**AND**

2. Documented resistance or intolerance to prior therapy, including imatinib

**AND**

3. The prescribing physician is an oncologist

### **Tazverik (tazemetostat)**

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The plan may authorize coverage of Tazverik (tazemetostat) for Members when the following criteria are met:

#### **Epithelioid Sarcoma**

1. Documented diagnosis of metastatic or locally advanced epithelioid sarcoma not eligible for complete resection

**AND**

2. The Member is 16 years of age or older

**AND**

3. The prescribing physician is an oncologist

#### **Relapsed or Refractory Follicular Lymphoma**

1. Documented diagnosis of relapsed or refractory follicular lymphoma

**AND**

2. The prescribing physician is an oncologist or hematologist

**AND**

3. Documentation of one of the following:

- a. No satisfactory alternative treatment options
- b. Tumors are positive for an EZH2 mutation as detected by an FDA approved test and the Member has received at least two prior systemic therapies

#### **Tepmetko (tepotinib)**

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The plan may authorize coverage of Tepmetko (tepotinib) for Members when the following criteria are met:

1. Documented diagnosis of metastatic non-small cell lung cancer

**AND**

2. Documentation the tumors have a mutation that leads to MET exon 14 skipping

**AND**

3. The prescribing physician is an oncologist

#### **Tibsovo (ivosidenib)**

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The plan may authorize coverage of Tibsovo (ivosidenib) for Members when **ALL** of the following criteria are met:

##### **Acute Myeloid Leukemia**

1. Documented diagnosis of acute myeloid leukemia with a susceptible IDH1 mutation as detected by an FDA-approved test

**AND**

2. The prescribing physician is an oncologist or hematologist

**AND**

3. Documentation of **one (1)** of the following:

- a. Relapsed or refractory acute myeloid leukemia
- b. Documentation of **ALL** of the following:
  - i. Member is at least 75 years of age or comorbidities that preclude use of intensive induction chemotherapy
  - ii. Newly-diagnosed acute myeloid leukemia

##### **Cholangiocarcinoma**

1. Documented diagnosis of locally advanced or metastatic cholangiocarcinoma with a susceptible IDH1 mutation as detected by an FDA-approved test

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Documentation the Members has received prior treatment

#### **Truqap (capivasertib)**

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The plan may authorize coverage of Truqap (capivasertib) for Members when **ALL** of the following criteria are met:

1. Documented diagnosis of hormone receptor-positive, human epidermal growth factor receptor 2-negative, locally advanced or metastatic breast cancer

**AND**

2. Documentation of one or more PIK3CA/AKT1/PTEN-alterations as detected by an FDA-approved test

**AND**

3. Documentation of **one (1)** of the following:
  - a. Disease progression on at least one endocrine-based regimen in the metastatic setting
  - b. Recurrence on or within 12 months of completing adjuvant therapy

**AND**

4. Documentation the requested medication will be used in combination with fulvestrant

**AND**

5. The prescribing physician is an oncologist

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**Truseltiq (infigratinib)**

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The plan may authorize coverage of Truseltiq (infigratinib) for Members when **ALL** of the following criteria are met:

1. Documented diagnosis of locally advanced or metastatic cholangiocarcinoma

**AND**

2. Documentation the cancer has a fibroblast growth factor receptor 2 fusion or other rearrangement as detected by an FDA-approved test

**AND**

3. The prescribing physician is an oncologist

**AND**

4. Documentation the cancer is unresectable

**AND**

5. Documentation the Member has received prior treatment

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**Tukyasa (tucatinib)**

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The plan may authorize coverage of Tukysa (tucatinib) for Members when **ALL** of the following criteria are met:

**Metastatic Breast Cancer**

1. Documented diagnosis of advanced unresectable or metastatic HER2-positive breast cancer

**AND**

2. Documentation of use in combination with trastuzumab and capecitabine

**AND**

3. Documentation the Member has received one or more prior anti-HER2-based regimens in the metastatic setting

**AND**

4. The prescribing physician is an oncologist

**Unresectable or Metastatic Colorectal Cancer**

1. Documented diagnosis of unresectable or metastatic RAS wild-type, HER2-positive colorectal cancer

**AND**

2. Documentation of use in combination with trastuzumab

**AND**

3. Documentation the patient has received treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy

**AND**

4. The prescribing physician is an oncologist

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**Turalio (pexidartinib)**

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The plan may authorize coverage of Turalio (pexidartinib) for Members when **ALL** of the following criteria are met:

1. Documented diagnosis of tenosynovial giant cell tumor

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Documentation the Member is symptomatic with severe morbidity or functional limitations

**AND**

4. Documentation the condition is not amenable to improvement with surgery

#### **Tykerb (lapatinib)**

---

The plan may authorize coverage of Tykerb (lapatinib) for Members when ALL of the following criteria are met:

##### **HER2 overexpressing advanced or metastatic breast cancer**

1. Documented diagnosis of HER2 overexpressing advanced or metastatic breast cancer

**AND**

2. Documentation the Member has failed prior therapy with an appropriate trial of an anthracycline and a taxane chemotherapeutic agent.

**AND**

3. Documentation the Member has failed prior therapy with an appropriate trial of Herceptin (trastuzumab).

**Note:** Prior therapy with Herceptin (trastuzumab) implies that the Member's diagnosis of HER2 overexpressing breast cancer has been confirmed via immunohistochemistry (IHC) or fluorescent in situ hybridization (FISH) assay.

**AND**

4. Documentation Tykerb (lapatinib) will be administered concurrently with capecitabine (Xeloda®)

**AND**

5. The prescribing physician is an oncologist

##### **Hormone-receptor positive metastatic breast cancer in post-menopausal women**

1. Documented diagnosis of hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor

**AND**

2. Documentation Tykerb (lapatinib) will be administered concurrently with an aromatase inhibitor

**AND**

3. The prescribing physician is an oncologist

#### **Vanflyta (quizartinib)**

---

The plan may authorize coverage of Vanflyta (quizartinib) for Members when **ALL** of the following criteria are met:

1. Documented diagnosis of newly diagnosed acute myeloid leukemia

**AND**

2. Documentation of FLT3 internal tandem duplication (ITD)-positive disease

**AND**

3. Documentation the physician is an oncologist or hematologist

#### **Venclexta (venetoclax)**

---

The plan may authorize coverage of Venclexta (venetoclax) when **ALL** of the following criteria are met:

##### **Acute myeloid leukemia**

1. Documented diagnosis of acute myeloid leukemia

**AND**

2. Documentation of one of the following:

- a) The Member is at least 75 years of age or older
- b) Comorbidities that preclude use of intensive induction chemotherapy

**AND**

3. Documentation of use in combination with azacitidine, decitabine, or cytarabine

**AND**

4. The prescribing physician is an oncologist or a hematologist

##### **Chronic lymphocytic leukemia and Small lymphocytic leukemia**

1. Documented diagnosis of one (1) of the following:

- a. Chronic lymphocytic leukemia

- b. Small lymphocytic leukemia

**AND**

2. The prescribing physician is an oncologist or a hematologist

### **Verzenio (abemaciclib)**

---

The plan may authorize coverage of Verzenio (abemaciclib) for Members when the following criteria are met:

#### **Advanced or Metastatic Breast Cancer**

1. Documented diagnosis of advanced or metastatic breast cancer

**AND**

2. Documentation of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative disease

**AND**

3. The prescribing physician is an oncologist

#### **Early Breast Cancer**

1. Documented diagnosis of early breast cancer

**AND**

2. Documentation of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node-positive disease

**AND**

3. The prescribing physician is an oncologist

**AND**

4. Documentation of use in combination with endocrine therapy (e.g., tamoxifen, aromatase inhibitor)

**AND**

5. Documentation the patient is at high risk of recurrence

### **Vitrakvi (larotrectinib)**

---

The plan may authorize coverage of Vitrakvi (larotrectinib) for Members when the following criteria are met:

1. Documented diagnosis of a solid tumor that has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation

**AND**

2. The prescribing physician is an oncologist

**AND**

3. Documentation of both of the following:

- a) Member's disease is metastatic or surgical resection is likely to result in severe morbidity
- b) There are no satisfactory alternative treatments or Member's disease has progressed following treatment

### **Vizimpro (dacomitinib)**

---

The plan may authorize coverage of Vizimpro (dacomitinib) for Members when **ALL** of the following criteria are met:

1. Documented diagnosis of metastatic non-small cell lung cancer whose tumors have epidermal growth factor exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test

**AND**

2. The prescribing physician is an oncologist

### **Vonjo (pacritinib)**

---

The plan may authorize coverage of Vonjo (pacritinib) for Members when **ALL** of the following criteria are met:

1. Documented diagnosis of intermediate- or high-risk primary or secondary myelofibrosis

**AND**

2. The prescribing physician is an oncologist or hematologist

**AND**

3. Documented platelet count below  $50 \times 10^9/L$

**Voranigo (vorasidenib)**

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1. Documented diagnosis of Grade 2 astrocytoma or oligodendroglioma with a susceptible isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation

**AND**

2. The patient has previously undergone surgery including biopsy, sub-total resection, or gross total resection

**AND**

3. The patient is at least 12 years of age or older

**AND**

4. Documentation Voranigo will be used as single agent

**AND**

5. The prescribing physician is an oncologist or hematologist

**Votrient (pazopanib)**

---

The plan may authorize coverage of Votrient (pazopanib) for Members when **ALL** of the following criteria are met:

**Advanced Renal Cell Carcinoma**

1. Documented diagnosis of advanced renal cell carcinoma

**AND**

2. The prescribing physician is an oncologist

**Advanced Soft Tissue Sarcoma**

1. Documented diagnosis of advanced soft tissue sarcoma

**AND**

2. The prescribing physician is an oncologist

**AND**

3. The Member has received prior chemotherapy, including anthracycline treatment, or was unsuited for such therapy

**Welireg (belzutifan)**

---

The plan may authorize coverage of Welireg (belzutifan) for Members when **ALL** of the following criteria are met:

**Advanced Renal Cell Carcinoma**

1. Documented diagnosis of advanced renal cell carcinoma

**AND**

2. Documentation of previous treatment with a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor and a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TK)

**AND**

3. The prescribing physician is an oncologist

**von Hippel-Lindau Disease**

1. Documented diagnosis of von Hippel-Lindau disease

**AND**

2. Documentation treatment is required for associated renal cell carcinoma (RCC), central nervous system (CNS) hemangioblastomas, or pancreatic neuroendocrine tumors

**AND**

3. The prescribing physician is an oncologist

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**Xalkori (crizotinib)**

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The plan may authorize coverage of Xalkori (crizotinib) for Members when **ALL** of the following criteria are met:

**Anaplastic Large Cell Lymphoma**

1. Documented diagnosis of anaplastic lymphoma kinase (ALK)-positive anaplastic large cell lymphoma
- AND**
2. Member is at least 1 year of age or older

**Myofibroblastic Tumors**

1. Documented diagnosis of anaplastic lymphoma kinase (ALK)-positive unresectable, recurrent or refractory inflammatory myofibroblastic tumor
- AND**
2. The prescribing physician is an oncologist

**Non-small Cell Lung Cancer**

1. Documented diagnosis of metastatic non-small cell lung cancer
- AND**
2. The prescribing physician is an oncologist
- AND**
3. Documentation the tumors are anaplastic lymphoma kinase (ALK) or ROS1-positive as detected by an FDA-approved test

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**Xospata (gilteritinib)**

---

The plan may authorize coverage of Xospata (gilteritinib) for Members when **ALL** of the following criteria are met:

1. Documented diagnosis of relapsed or refractory acute myeloid leukemia
- AND**
2. The prescribing physician is an oncologist or hematologist
- AND**
3. Documentation of a FLT3 mutation as detected by an FDA-approved test

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**Xpovio (selinexor)**

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The plan may authorize coverage of Xpovio (selinexor) for Members when **ALL** of the following criteria are met:

**Diffuse Large B-Cell Lymphoma**

1. Documented diagnosis of relapsed or refractory diffuse large B-cell lymphoma
- AND**
2. The prescribing physician is an oncologist or hematologist
- AND**
3. Documentation the Member has received at least two prior lines of systemic therapy

**Multiple Myeloma**

1. Documented diagnosis of multiple myeloma
- AND**
2. The prescribing physician is an oncologist or hematologist
- AND**
3. Documentation the Member has received at least one prior therapy

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**Xtandi (enzalutamide)**

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The plan may authorize coverage of Xtandi (enzalutamide) for Members when **ALL** of the following criteria are met:

1. The prescribing physician is an oncologist or urologist
- AND**
2. Documented diagnosis of one of the following:
    - a) Castration-resistant prostate cancer



- b) Metastatic castration-sensitive prostate cancer

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**Zejula (niraparib)**

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The plan may authorize coverage of Zejula (niraparib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer  
**AND**
2. Documentation of **one (1)** of the following:
  - a. Advanced disease in a patient with complete or partial response to first-line platinum-based chemotherapy
  - b. Recurrent disease with a deleterious or suspected deleterious germline BRCA-mutation in a patient with complete or partial response to platinum-based chemotherapy**AND**
3. The prescribing physician is an oncologist

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**Zelboraf (vemurafenib)**

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The plan may authorize coverage of Zelboraf (vemurafenib) for Members when **ALL** of the following criteria are met:

**Melanoma**

1. Documented diagnosis of unresectable or metastatic melanoma  
**AND**
2. The prescribing physician is an oncologist  
**AND**
3. The Member has BRAF V600E mutation-positive melanoma as detected by an FDA-approved test

**Erdheim-Chester Disease**

1. Documented diagnosis of Erdheim-Chester Disease with BRAF V600 mutation

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**Zolinza (vorinostat)**

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The plan may authorize coverage of Zolinza (vorinostat) for Members when **ALL** of the following criteria are met:

1. Documented diagnosis of advanced cutaneous T-cell lymphoma (Stage IIB and higher)  
**AND**
2. Documentation the Member has progressive, persistent or recurrent disease  
**AND**
3. Documentation of current or prior treatment or treatment failure with at least one systemic chemotherapeutic agent for cutaneous T-cell lymphoma  
**AND**
4. The prescribing physician is an oncologist or hematologist

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**Zydelig (idelalisib)**

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The plan may authorize coverage of Zydelig (idelalisib) for Members when **ALL** of the following criteria are met:

1. Documented diagnosis of relapsed chronic lymphocytic leukemia  
**AND**
2. The prescribing physician is an oncologist or hematologist  
**AND**
3. Documentation Zydelig (idelalisib) will be given in combination with rituximab

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**Zykadia (ceritinib)**

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The plan may authorize coverage of Zykadia (ceritinib) for Members, when **ALL** of the following criteria are met:

1. Documented diagnosis of metastatic non-small cell lung cancer  
**AND**
2. The prescribing physician is an oncologist

**AND**

3. Documentation the Member has anaplastic lymphoma receptor tyrosine kinase (ALK) genetic mutation as detected by a Food and Drug Administration-approved test

**Off-label Use Coverage for Other Cancer Diagnoses**

Coverage for other cancer diagnoses may be authorized provided effective treatment with such drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the Massachusetts commissioner of Insurance (commissioner) under the provisions of the "Sullivan Law": (M.G.L. c.175, s.47K ).

The plan may authorize coverage for use for other cancer diagnoses provided effective treatment with such drug is recognized as a "Medically Accepted Indication" according to the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium as indicated by a Category 1 or 2A for quality of evidence and level of consensus.

**Note:** The plan requires prescribers to submit clinical documentation supporting the drug's effectiveness in treating the intended malignancy, including the applicable NCCN guideline(s).

In cases where the requested off-label use for the diagnosis is not recognized by the NCCN Drugs and Biologics Compendium, the plan will follow the Centers for Medicare and Medicaid Services (CMS) guidance, unless otherwise directed by the commissioner, and accept clinical documentation referenced in one of the other "Standard Reference Compendia" noted below or supported by clinical research that appears in a regular edition of a "Peer-Reviewed Medical Literature" noted below.

- |  |  |
|--|--|
| • American Journal of Medicine   | • Gynecologic Oncology   |
| • Annals of Internal Medicine  | • International Journal of Radiation, Oncology, Biology, and Physics |
| • Annals of Oncology   | • The Journal of the American Medical Association                    |
| • Annals of Surgical Oncology  | • Journal of Clinical Oncology                                       |
| • Biology of Blood and Marrow Transplantation  | • Journal of the National Cancer Institute                           |
| • Blood  | • Journal of the National Comprehensive Cancer Network (NCCN)        |
| • Bone Marrow Transplantation  | • Journal of Urology   |
| • British Journal of Cancer  | • Lancet   |
| • British Journal of Hematology  | • Lancet Oncology  |
| • British Medical Journal  | • Leukemia   |
| • Cancer   | • The New England Journal of Medicine                                |
| • Clinical Cancer Research   | • Radiation Oncology   |
| • Drugs  |  |
| • European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology) |  |

**"Standard Reference Compendia"**

1. American Hospital Formulary Service – Drug Information (AHFS-DI)
2. Thomson Micromedex DrugDex
3. Clinical Pharmacology (Gold Standard)
4. Wolters Kluwer Lexi-Drugs

**"Peer Reviewed Medical Literature"**

When the plan evaluates the evidence in published, peer-reviewed medical literature, consideration will be given to the following:

1. Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.

2. Whether the administered chemotherapy regimen is adequately represented in the published evidence.
3. Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
4. Whether the study is appropriate to address the clinical question.
  - a. whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question (for example, in some clinical studies it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover);
  - b. that non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs; and,
  - c. that case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.

#### **LIMITATIONS**

- Approval duration of Ogsiveo will be limited to 12-months.
- Authorizations of Iwilfin will be limited to 2 years.
- The plan will not authorize the use of an oral cancer medication for a condition other than those listed above without appropriate documentation.
- The plan does not cover multi-source branded oral cancer medications. Refer to the Pharmacy Medical Necessity Guidelines for Non-covered Drugs with Suggested Alternatives.
- The plan does not cover the following medications: Erleada, Nubeqa, Yonsa, and Zytiga 500 mg.

#### **CODES**

None

#### **REFERENCES**

1. Drugs@FDA: FDA-Approved Drugs [website on the internet]. Available from: <https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm>. Accessed March 2025.
2. The Desmoid Tumor Working Group. The management of desmoid tumors: A joint global consensus-based guideline approach for adult and paediatric patients, 2020. European journal of cancer. March 2020;127:96-107.

#### **APPROVAL HISTORY**

September 13, 2022: Reviewed by Pharmacy & Therapeutics Committee.

1. January 10, 2023: Added Lytgobi to the Medical Necessity Guideline.
2. March 14, 2023: Added Krazati and Rezlidhia to the Medical Necessity Guideline (effective 5/1/23). Added coverage criteria for the supplemental indication for Tukysa in unresectable or metastatic colorectal cancer (effective 5/1/23). Removed Ukoniq from the Medical Necessity Guideline because the drug has been discontinued (effective 5/1/23). Updated coverage criteria for the following based on updated package labeling: Rubraca for ovarian cancer, Zejula for ovarian cancer (effective 5/1/23).
3. April 11, 2023: Added Jaypirca and Orserdu to the Medical Necessity Guideline (effective 6/1/23).
4. July 11, 2023: Added coverage criteria for the supplemental indication for Ayvakit in indolent systemic mastocytosis. Added coverage criteria for the supplemental indication for Lynparza in BRCA-mutated metastatic castration-resistant prostate cancer in combination with abiraterone and prednisone or prednisolone. Updated Verzenio's coverage criteria in early breast cancer based on updated package labeling to no longer a Ki-67 score of at least 20% as determined by a Food and Drug Administration-approved test. Added coverage criteria for the supplemental indication for Tafenlar and Mekinist in BRAF V600E mutation-positive low-grade glioma. Added coverage criteria for supplemental indication for Tafenlar in solid tumors (effective 8/1/23).
5. August 8, 2023: Added coverage criteria for the supplemental indication for Talzenna in HRR gene-mutated metastatic castration-resistant prostate cancer (effective 9/1/23).
6. September 12, 2023: Added coverage criteria for the supplemental indication Brukinsa in chronic lymphocytic leukemia or small lymphocytic leukemia (effective 10/1/2023).
7. October 10, 2023: Added Vanflyta to the Medical Necessity Guideline (effective 11/1/2023).
8. December 12, 2023: Added Ojjaara to the Medical Necessity Guideline (effective 1/1/2024).
9. January 9, 2023: Added Akeega to the Medical Necessity Guideline. Expanded provider specialty requirements to "The prescribing physician is an oncologist, hematologist, immunologist, or allergist" for Rydapt and Ayvakit for systemic mastocytosis indications (effective 2/1/2024).

10. February 13, 2024: Added Augtyro Fruzaqla, Ogsiveo, and Truqap to the Medical Necessity Guideline (effective 3/1/2024).
11. March 12, 2024: Added Iwilfin to the Medical Necessity Guideline (effective 4/1/2024).
12. June 11, 2024: Added coverage criteria for Welireg's supplemental indication for advanced renal cell carcinoma (eff 7/1/24).
13. August 13, 2024: Added coverage criteria for Retevmo's supplemental indication for other RET fusion-positive solid tumors. Updated age requirements for Retevmo to at least 2 year of age for RET-mutant medullary thyroid cancer and RET fusion-positive thyroid cancer. Updated coverage for Iclusig to address expanded indication in newly diagnosed Ph+ ALL in combination with chemotherapy. Added Ojemda to the Medical Necessity Guideline (eff 9/1/24).
14. November 12, 2024: Removed coverage criteria for Gavreto Medullary Thyroid Cancer based on the FDA removing the indication from package labeling. Added coverage criteria for Kisqali's supplemental indication in early breast cancer. Added Lazcluze and Voranigo to the Medical Necessity Guideline (eff 12/1/24).
15. December 10, 2024: Added Itovebi to the Medical Necessity Guideline (eff 2/1/25).
16. February 11, 2025: Updated the coverage criteria for Calquence based on the expanded indication in mantle cell lymphoma. Added Revuforj to the Medical Necessity Guideline (eff 3/1/25).
17. April 8, 2025: Updated coverage criteria for Braftovi and Mektovi based on the supplemental indication in metastatic non-small cell lung cancer (eff 5/1/25).

#### **BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION**

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

[Provider Services](#)