# Iclusig™ (ponatinib)
## (Oral)

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## I. Length of Authorization

Coverage will be provided for six months and may be renewed.

## II. Dosing Limits

**A. Quantity Limit (max daily dose) [Pharmacy Benefit]:**

- Iclusig 15 mg tablet: 2 tablets per day
- Iclusig 30 mg tablet: 1 tablet per day
- Iclusig 45 mg tablet: 1 tablet per day

**B. Max Units (per dose and over time) [Medical Benefit]:**

- 45 mg daily

## III. Initial Approval Criteria

Coverage is provided in the following conditions:

- Patient has had a comprehensive baseline eye exam; **AND**

**Acute lymphoblastic leukemia (ALL) †**

- Patient's disease is Philadelphia chromosome-positive (Ph+); **AND**
- Patient is aged at least 15 years old; **AND**
  - Disease is T315I mutation positive †; **OR**
  - Patient has failed multiple tyrosine kinase inhibitors (TKI) †; **OR**
  - Used as single agent or in combination with an induction regimen not previously given for relapsed/refractory disease; **OR**
  - Used as part of induction/consolidation therapy in combination with HyperCVAD (hyper-fractionated cyclophosphamide, vincristine, doxorubicin, and dexamethasone, alternating with high-dose methotrexate and cytarabine); **OR**
  - Used as maintenance therapy; **AND**
    - In combination with vincristine and prednisone; **OR**
    - Post hematopoietic stem-cell transplant

**Chronic myelogenous leukemia (CML) †**

- Patient is at least 18 years old; **AND**
- *BCR-ABL1* positive laboratory test result; **AND**
  - Patient has chronic or accelerated or blast phase disease †; **AND**

- Patient's disease is T315I mutation positive †; **OR**
- Patient is resistant, or intolerant, or had an inadequate response to prior tyrosine kinase inhibitor (TKI) therapies, consisting of a 3 month trial or longer, with any of the following: omacetaxine, imatinib, dasatinib, bosutinib, nilotinib, etc. †; **OR**

o Used as primary treatment ‡; **AND**

- Used as single agent for accelerated phase disease; **OR**
- Used as single agent for myeloid blast phase disease; **OR**
- In combination with steroids for lymphoid blast phase disease; **OR**
- In combination with induction chemotherapy for lymphoid or myeloid blast phase disease; **OR**

o Post-allogeneic hematopoietic stem cell transplant (HCT) ‡; **AND**

- Used in patients with a complete cytogenetic response (CCyR) for accelerated or blast phase disease; **OR**
- Used in patients with molecular relapse (BCR-ABL1 transcript positive) following CCyR; **OR**
- Used as follow-up therapy in patients with relapse or those who are not in CCyR

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s)

## IV. Renewal Criteria

Coverage can be renewed based upon the following criteria:

- Patient continues to meet criteria in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: thromboembolism and vascular occlusion; hepatotoxicity; ocular toxicity; hypertensive crisis; serious congestive heart failure; pancreatitis; serious or severe hemorrhage; fluid retention (peripheral edema, pleural effusion, and pericardial effusion); cardiac arrhythmia; Grade 3 or 4 myelosuppression; tumor lysis syndrome; gastrointestinal perforation; poor wound healing; **AND**
- Patient has been adherent to therapy; **AND**
- Patient has received periodic comprehensive eye exams

**Acute lymphoblastic leukemia (ALL) only:**

- Treatment response or stabilization of disease as indicated by CBC, bone marrow cytogenic analysis, QPCR, or FISH

**Chronic Myelogenous Leukemia (CML) only:**

- Treatment response as indicated by one of the following *BCR-ABL1* (IS) transcript levels:
  - ≤ 10% at 3 months; **OR**
  - ≤ 10% at 6 months; **OR**
  - < 1% at 12 months; **OR**
  - < 0.1% beyond 12 months

  NOTE: cytogenetic assessment of response may be used if quantitative RT-PCR (QPCR) using International Scale (IS) for *BCR-ABL1* is not available

## V. Dosage/Administration

| Indication | Dose |
|---|---|

| | |
|---|---|
| All Indications | 45 mg administered orally once daily. |

## VI. Billing Code/Availability Information

Jcode:

- C9399: Unclassified drugs or biologicals, (*Hospital Outpatient Use ONLY*)
- J8999: Prescription drug, oral, chemotherapeutic, NOS

NDC:

- Iclusig 15 mg tablet: 63020-0535-xx
- Iclusig 30 mg tablet: 63020-0533-xx
- Iclusig 45 mg tablet: 63020-0534-xx

## VII. References


1. Iclusig [package insert]. Cambridge, MA; Takeda Pharmaceuticals Company Limited; October 2018. Accessed June 2019.
2. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) for Acute Lymphoblastic Leukemia. 2.2019. National Comprehensive Cancer Network, 2019. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed June 2019.
3. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) for Chronic Myelogenous Leukemia 1.2019. National Comprehensive Cancer Network, 2019. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed June 2019.
4. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) for ponatinib. 2019 National Comprehensive Cancer Network. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed June 2019.


## Appendix 1 – Covered Diagnosis Codes

| ICD-10 | ICD-10 Description |
|---|---|
| C91.00 | Acute lymphoblastic leukemia, not having achieved remission |
| C91.01 | Acute lymphoblastic leukemia, in remission |
| C91.02 | Acute lymphoblastic leukemia, in relapse |
| C92.10 | Chronic myeloid leukemia, BCR/ABL-positive, not having achieved remission |
| C92.11 | Chronic myeloid leukemia, BCR/ABL-positive, in remission |
| C92.12 | Chronic myeloid leukemia, BCR/ABL-positive, in relapse |

## Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination

(NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD): N/A

| Medicare Part B Administrative Contractor (MAC) Jurisdictions | | |
|---|---|---|
| **Jurisdiction** | **Applicable State/US Territory** | **Contractor** |
| E (1) | CA, HI, NV, AS, GU, CNMI | Noridian Healthcare Solutions, LLC |
| F (2 & 3) | AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ | Noridian Healthcare Solutions, LLC |
| 5 | KS, NE, IA, MO | Wisconsin Physicians Service Insurance Corp |
| 6 | MN, WI, IL | National Government Services, Inc. (NGS) |
| H (4 & 7) | LA, AR, MS, TX, OK, CO, NM | Novitas Solutions, Inc. |
| 8 | MI, IN | Wisconsin Physicians Service Insurance Corp |
| N (9) | FL, PR, VI | First Coast Service Options, Inc. |
| J (10) | TN, GA, AL | Palmetto GBA, LLC |
| M (11) | NC, SC, WV, VA (excluding below) | Palmetto GBA, LLC |
| L (12) | DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA) | Novitas Solutions, Inc. |
| K (13 & 14) | NY, CT, MA, RI, VT, ME, NH | National Government Services, Inc. (NGS) |
| 15 | KY, OH | CGS Administrators, LLC |