Clinical Policy: Bosutinib (Bosulif)

Reference Number: CP.PHAR.105
Effective Date: 10.01.12
Last Review Date: 05.18
Line of Business: Commercial, HIM, Medicaid Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Bosutinib (Bosulif®) is a kinase inhibitor.

FDA Approved Indication(s)

Bosulif is indicated for the treatment of adult patients with:

- Newly-diagnosed chronic phase (CP) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML). This indication is approved under accelerated approval based on molecular and cytogenetic response rates. Continued approval for this indication may be contingent upon verification and confirmation of clinical benefit in an ongoing long-term follow up trial
- Chronic phase, accelerated phase (AP), or blast phase (BP) Ph+ CML with resistance or intolerance to prior therapy

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Bosulif is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Myelogenous Leukemia (must meet all)**:**

1. Diagnosis of Ph+ (i.e., BCR-ABL1+) CML;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Dose does not exceed 600 mg per day.

Approval duration:
Medicaid/HIM - 6 months
Commercial - Length of Benefit

B. Acute Lymphoblastic Leukemia (off-label) (must meet all)**:**

1. Diagnosis of Ph+ (i.e., BCR-ABL1+) acute lymphoblastic leukemia (ALL);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Request meets one of the following (a or b):
   a. Dose does not exceed 600 mg/day;

b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:
Medicaid/HIM - 6 months
Commercial - Length of Benefit

C. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Bosulif for Ph+ CML and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed the following (a or b)
   a. Dose does not exceed 600 mg/day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:
Medicaid/HIM - 12 months
Commercial - Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALL: acute lymphoblastic leukemia
AP: accelerated phase
BP: blast phase
CML: chronic myelogenous leukemia
CP: chronic phase
FDA: Food and Drug Administration

Ph+: Philadelphia chromosome-positive

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: General Information
CML is defined by the presence of Philadelphia chromosome (Ph) in a patient with a myeloproliferative neoplasm. Ph results from a reciprocal translocation between chromosomes 9 and 22 that gives rise to a BCR-ABL1 fusion gene; the product of this fusion gene is a protein with deregulated tyrosine kinase activity that plays a central role in the pathogenesis of CML (NCCN Guidelines, Version 3.2018, Chronic Myeloid Leukemia).

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Newly-diagnosed CP Ph+ CML	400 mg PO QD	600 mg/day
CP, AP, or BP Ph+ CML with resistance or intolerance to prior therapy	500 mg PO QD	600 mg/day

VI. Product Availability

Tablets: 100 mg, 400 mg, 500 mg

VII. References

1. Bosulif Prescribing Information. New York, NJ: Pfizer Inc.; December 2017. Available at https://www.bosulif.com. Accessed January 2018.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at http://www.nccn.org/professionals/drug_compendium. Accessed January 2018.
3. National Comprehensive Cancer Network. Chronic Myeloid Leukemia Version 3.2018. Available at www.nccn.org. Accessed January 2018.
4. Acute lymphoblastic leukemia (Version 5.2017). In: National Comprehensive Cancer Network Guidelines. Available at www.nccn.org. Accessed February 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Updated background information Added Table 1: Efficacy of Bosulif in Previously-Treated Patients	11.14	12.14
Converted policy to new template. Criteria: deleted question about using Bosulif as monotherapy as there are circumstances where Bosulif is used with chemotherapy; removed dosing question; removed detailed questions about therapy response due to complexity of monitoring parameters and replaced with general question about disease progression. Background: limited to PI and NCCN-based narrative; removed clinical trial and safety discussion. Removed appendices discussing types of therapy responses and lists of therapeutic options.	10.15	11.15

Updated policy template. Added preferencing for first line TKI therapy (imatinib, dasatinib, nilotinib). Modified indication to include Bcr-Abl1+ CML. Added maximum dose criteria. Removed safety appendix and incorporated contraindications and reasons to discontinue directly into criteria set. Removed positive T315I/V299L point mutation from contraindication criteria.	10.16	11.16
Converted to new template. Modified approval duration from 3 to 6 months for initial approval; added documentation of positive response to therapy renewal criteria; modified approval duration from 6 to 12 months for renewal. Safety criteria was applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs.	09.17	11.17
Policies combined for Centene Medicaid and Commercial lines of business. Added HIM line of business to policy. Specialist added. Due to the addition of the new FDA indication for Bosulif in the primary therapy setting the criteria are represented at a high level to encompass both the FDA indications and NCCN recommended uses: AP or BP Ph+ CML primary therapy, post HCT therapy, first- or second-line therapy for the following point mutations (E255K/V, F317L/V/I/C, F359V/C/I, T315A, or Y253H). Preference for imatinib in the primary therapy setting is removed given Bosulif's new FDA labeled use. COC added. References reviewed and updated.	01.23.18	02.18
2Q2018 annual review: off-label ALL added; references updated.	2.13.18	05.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.