MEDICATION COVERAGE POLICY

PHARMACY AND THERAPEUTICS ADVISORY COMMITTEE

Health Plan of San Joaquin

POLICY	Cancer	**LAST REVIEW**	9/15/20
THERAPEUTIC CLASS	Oncology	**REVIEW HISTORY** (MONTH/YEAR)	9/19, 9/18, 5/17, 5/16
LOB AFFECTED	Medi-Cal		

This policy has been developed through review of medical literature, consideration of medical necessity, generally accepted medical practice standards, and approved by the HPSJ Pharmacy and Therapeutic Advisory Committee.

OVERVIEW

Oncology medications account for one of the largest drug spend in the United States. In more recent years, drug innovative companies have had tremendous success—releasing numerous new drugs on the market each year—with the latest goal to develop targeted cancer tumor cells as opposed to the traditional, cytotoxic chemotherapy agents. The below criteria, limits, and requirements for HPSJ's formulary oncology agents.

***Note:** This coverage policy strictly reviews the agents used specifically for the treatment or management of cancer. For **Antiemetic Agents**, please refer to Coverage Policy – Gastrointestinal Disorders – Nausea. For **ESAs** (i.e. Epogen), please refer to Coverage Policy –Renal – Anemia. For agents that do not have established prior authorization criteria or agents that are "Non-Formulary," HPSJ will make the determination based on the National Comprehensive Cancer Network (NCCN) Guidelines and Medical Necessity criteria as described in HPSJ Medical Review Guidelines (UM06).*

Formulary Status *(Current as of 6/2020)*

Therapeutic Class	Generic Name (Brand Name)	Procedure Code	Available Strengths	Form. Limits	Average Cost per 30 days	Notes
Alkylating Agents	Altretamine (Hexalen) *Capsule*	--	50mg	PA, SP	$3,604.52*	
	Bendamustine (Belrapzo, Bendeka, Treanda) IV		100mg/4 ml	PA, SP	--	
			25 mg vial	PA, SP	--	
			100 mg vial	PA, SP	--	
	Busulfan (Myleran, Busulfex) *Tablet, IV*	--	2mg tab	PA, SP	--	
		--	60mg/10ml		--	
	Dacarbazine *IV*	--	100 mg	NF	--	
		--	200 mg		--	
	Procarbazine (Matulane) *Capsule*	--	50mg	PA, SP	$2,429.63	
	Temozolomide (Temodar) *Capsule, IV*	J8700	5mg Capsule	PA, SP	--	
		J9328	20mg		--	
			100mg		--	
			140mg		--	
			250mg		--	
			280mg		--	
			IV: 100mg		--	

	Nitrogen Mustard					
	Bendamustine (Bendeka, Treanda) *IV*	J9033 (Bendeka)	25 mg	NF	--	
		J9034 (Treanda)	100 mg		--	
	Chlorambucil (Leukeran) *Tablet*	--	2mg	PA, SP	$368.89*	
	Cyclophosphamide *Capsule*	J8530	25mg	PA, SP	$328.99	
		--	50 mg	PA, SP	--	
	Cyclophosphamide *Vial*	J9070	500mg	PA, SP	$854.58	
			1 gram	PA, SP	--	
			2 gram	PA, SP	--	
	Melphalan (Alkeran) *Tablet*	--	2mg	PA, SP	$2,335.5*	
	Estrogen/Nitrogen Mustard					
	Estramustine (Emcyt) *Capsule*	--	140mg	PA, SP	$3,372.60*	
	Nitrosurea					
	Carmustine (BiCNU) *IV*	--	100mg	PA, SP	$3,084.3*	
	Lomustine (Ceenu) *Capsule*	--	10mg	PA, SP	--	
		--	40mg		--	
		--	100mg		--	
	Streptozocin (Zanosar)	--	1gram	PA, SP	$1,676.00	
	Platinum Analog					
	Carboplatin (Paraplatin) *IV*	J9045	600 mg/60 ml	NF	$43.80	
	Cisplatin *IV*	J9060	50 mg/50 ml	NF	$12.50	
	Oxaliplatin (Eloxatin) *IV*	J9263	50mg/10ml,	PA, SP	--	
			100mg/20ml		--	
Anti-androgens	Abiraterone Acetate (Yonsa, Zytiga) *Tablet*	--	125 mg	PA, SP	--	
			250 mg		--	
			500 mg		--	
	Apalutamide (Erleada) *Tablet*	--	60 mg	PA, SP	--	
	Bicalutamide (Casodex) *Tablet*	--	50mg	--	$8.28	
	Enzalutamide (Xtandi) *Capsule*	--	40 mg	PA, SP	--	
	Nilutamide (Nilandron) *Tablet*	--	150mg	PA, SP	$8,696.34*	
	Flutamide (Euflex) *Capsule*	--	125mg	PA, SP	$231.61	
Antineoplastic Antibiotic	Bleomycin Sulfate (Blenoxane) *IV*		15 unit	PA, SP	--	
			30 unit		--	
	Dactinomycin (Cosmegen) *IV*		0.5 mg	PA, SP	$3,040.50*	

	Mitomycin (Mutamycin) *IV*		5mg	PA, SP	--	
			20mg		--	
			40mg		--	
Monclonal Antibody	Ipilimumab (Yervoy) *IV*	J9228	50 mg	PA, SP	--	
			200 mg		--	
Anti-HER2	**Monoclonal Antibody**					
	Pertuzumab (Perjeta) *IV*	J9306	420mg/14ml	PA, SP	$18,045.00*	
	Trastuzumab (Herceptin, Kajinti, Ogivri, Trazimera) *IV*	J9355	150mg	PA, SP	$9,644.09*	
			420mg	PA, SP	$9,644.09*	
	Trastuzumab and Hyaluronidase (Herceptin Hylecta) *SQ*	--	600 mg	NF	--	
	Monoclonal Antibody, Antimicrotubular					
	Ado-Trastuzumab emtansine (Kadcyla) *IV*	J9354	100 mg	PA, SP	--	
			160 mg	PA, SP	--	
	Monoclonal Antibody, Anti-PD-L1					
	Atezolizumab (Tecentriq) *IV*	J9022	840 mg/14 ml	PA, SP	--	
			1200 mg/20 mL	PA, SP	$10,656.65*	
	Avelumab (Bavencio) *IV*	--	200 mg/10 ml	PA, SP	$1,859.52*	
	Durvalumab (Imfinzi) *IV*	--	120mg/2.4ml	PA,SP	--	
			500mg/10ml	PA,SP	--	
	Monoclonal Antibody, Anti-CD20					
	Rituximab (Rituxan) *IV*	J9312	10mg/ml	PA, SP	$12,624.69*	10mg/ml
	Rituximab hyaluronidase *IV*	J9311	10 mg	NF	--	
	Monoclonal Antibody, Topoisomerase I Inhibitor					
	Fam-Trastuzumab Deruxtecan (Enhertu) *IV*	--	100 mg	PA, SP	--	
	Monoclonal Antibody, Topoisomerase I & II Inhibitor					
	Sacituzumab Govitecan (Trodelvy) *IV*	--	180 mg	PA, SP	--	
	Topoisomerase II Inhibitor					
	DOXOrubicin (Adriamycin, Myocet) *IV*	Q2050	2 mg/ml	PA, SP	--	
			50 mg		--	
	EpiRUBicin (Ellence) *IV*	J9178	50 mg/25 ml	PA, SP	--	
			200 mg/100 ml		--	
	Tyrosine Kinase Inhibitor					
	Tucatinib (Tukysa) *Tablet*	--	50 mg	PA, SP	$16,560	
			150 mg	PA, SP	$11,100	
	Epidermal Growth Factor Receptor (EGFR) Inhibitor, Tyrosine Kinase Inhibitor					
	Lapatinib (Tykerb) Tablet	--	250mg	PA, SP	$4,852.90*	

	Neratinib (Nerlynx) Tablet	--	40 mg	PA, SP	--	
	Combination agents					
	Pertuzumab, Trastuzumab, and Hyaluronidase (Phesgo) *SQ*	--	60 mg/60 mg/2,000 units/ ml	PA, SP	--	
			80 mg/40 mg/2,000 units/ml	PA, SP	--	
Anti-CD19/CD3	Blinatumomab (Blincyto) *IV*	--	35 mcg	PA, SP	--	
Anti-CD20	Obinutuzumab (Gazyva) *IV*	J9301	1000 mg	PA, SP	--	
Anti-CD30	Brentuximab Vedotin (Adcetris) *IV*		50 mg	PA, SP	--	
Anti-CD38	Daratumumab (Darzalex) *IV*	J9145	100 mg/5 ml	PA, SP	--	
			400 mg/20 ml	PA, SP	--	
Anti-PD-1	Nivolumab (Opdivo) *IV*	J9299	40 mg/4 ml	PA, SP	--	
			100 mg/10 ml	PA, SP	--	
			240 mg/24 ml	PA, SP	--	
	Pembrolizumab (Keytruda)	J9271	100 mg/4 ml	PA, SP	--	
BRAF Kinase Inhibitor	Darbrafenib (Tafinlar) *Capsule*		50 mg	PA, SP	--	
			75 mg	PA, SP	--	
	Encorafenib (Braftovi) *Capsule*		75 mg	PA, SP	--	
MEK inhibitor	Cobimetinib Fumarate (Cotellic) *Tablet*	J9999 C9399	20 mg	PA, SP	$6,677.33*	
	Trametinib Dimethyl Sulfoxide (Mekinist) *Tablet*	C9399 J3490 J8999	0.5mg	PA, SP	--	
			2mg	PA, SP	--	
mTOR Kinase Inhibitor	Everolimus (Afinitor) *Tablet*	--	2.5mg	PA, SP	--	
			5mg	PA, SP	--	
			7.5mg	PA, SP		
			10mg	PA, SP	--	
Vascular Endothelial Growth Factor (VEGF) Inhibitor	Bevacizumab (Avastin, Mvasi, Zirabev) *IV*	J9035	100 mg/4 ml	PA, SP	--	
			400 mg/16 ml	PA, SP	--	
Vascular Endothelial Growth Factor Receptor (VEGFR) 2 Inhibitor	Ramucirumab (Cyramza) *IV*	J9308	100 mg/10 ml	PA, SP	--	
			500 mg/50 ml	PA, SP	--	
Epidermal Growth Factor Receptor (EGFR)	Cetuximab (Erbitux) Inhibitor *IV*	J9055	200mg/100ml	PA, SP	--	
	Necitumumab (Portrazza) *IV*		800mg/50ml	PA, SP	--	
	Panitumumab (Vectibix) *IV*	J9303	100mg/5ml	PA, SP	--	
	DNA Methylation Inhibitor					
	Azacitidine (Vidaza) *IV*	J9025	100 mg	PA, SP	--	

	Decitabine (Dacogen) *IV*	J0894	50 mg	PA, SP	--	
Anti-metabolites	**Purine Analog**					
	Mercaptopurine (Purinethol)	--	50 mg	--	--	
	Pyrimidine Analog					
	Capecitabine (Xeloda) *Tablet*	--	150 mg	PA, SP	$1,552.78*	
			500 mg	PA, SP	--	
	Cytarabine (Cytosar) *IV*	XW033B3	20 mg /ml	PA, SP	--	
		XW043B3	100 mg/ml	PA, SP	--	
	Fluorouracil (Adrucil) *IV*	J9190	500 mg/10 ml	PA, SP	--	
			1 gram/20 ml	PA, SP	--	
			2.5 gram/50 ml	PA, SP	--	
			5 gram/100 ml	PA, SP	--	
	Fluorouracil (Carac, Efudex) *Cream, Solution*	--	Cream: 0.05%	--	--	
			Cream 0.1%	--	--	
			Cream: 0.5%	--	--	
			Solution: 0.2%	--	--	
			Solution 0.5%	--	--	
	Gemcitabine (Gemzar, Infugem) *IV*	J9201	200 mg	PA, SP	--	
			1 gram	PA, SP	--	
			2 gram	PA, SP	--	
			200 mg/2 ml	PA, SP	--	
			200 mg/5.26 ml	PA, SP	--	
			1 gram/10 ml	PA, SP	--	
			1 gram/26.3 ml	PA, SP	--	
			1.5 gram/15 ml	PA, SP	--	
			2 gram/20 ml	PA, SP	--	
			2 gram/52.6 ml	PA, SP	--	
		--	Infugem: Gemcitabine Hcl in 0.9%NaCl			
			1200 mg/120 ml	PA, SP	--	
			1300 mg/130 ml	PA, SP	--	
			1400 mg/140 ml	PA, SP	--	
			1500 mg/150 ml	PA, SP	--	
			1600 mg/160 ml	PA, SP	--	
			1700 mg/170 ml	PA, SP	--	
			1800 mg/180 ml	PA, SP	--	
			1900 mg/190 ml	PA, SP	--	
			2000 mg/200 ml	PA, SP	--	
			2200 mg/220 ml	PA, SP	--	
	Pyrimidine Analog, Thymidine Phosphorylase Inhibitor					
		--	15-16.4 mg	PA, SP	--	

	Trifluridine and Tipiracil (Lonsurf) *Tablet*		20-8.19 mg	PA, SP	--	
	Antifolate					
	Methotrexate (Trexall, Xatmep, Rasuvo, Otrexup, *Oral Tablet, oral solution, injectable*	--	2.5mg oral tabs	--	$21.51	
		--	Trexall oral tabs:			
			5 mg	NF	--	
			7.5 mg		--	
			10 mg		--	
			15 mg		--	
		--	Xatmep oral solution: 2.5 mg/ml	NF	--	
		--	Otrexup SQ auto injector:			
			10 mg/0.4 ml	NF	--	
			12.5 mg/0.4 ml		--	
			15 mg/0.4 ml		--	
			17.5 mg/0.4 ml		--	
			20 mg/0.4 ml		--	
			22.5 mg/0.4 ml		--	
			25 mg/0.4 ml		--	
		--	Rasuvo SQ auto injector:			
			7.5 mg/0.15 ml	NF	--	
			10 mg/0.2 ml		--	
			12.5 mg/0.25 ml		--	
			15 mg/0.3 ml		--	
			17.5 mg/0.35 ml		--	
			20 mg/0.4 ml		--	
			22.5 mg/0.45 ml		--	
			25 mg/0.5 ml		--	
			30 mg/0.6 ml		--	
		J9250	Solutions for injection:			
			50 mg/2 ml	NF	--	
			250 mg/10 ml	NF	--	
			1 gram/40 ml	NF	--	
			1 gram	NF	--	
	Pemetrexed (Alimta) *IV*	J9305	100mg	PA, SP	--	
			500mg	PA, SP	--	
	Thioguanine (Tabloid) *Tablet*	--	40mg	PA, SP	$902.39*	
Aromatase Inhibitors	Anastrozole (Arimidex) *Tablet*	--	1mg	--	$4.39	
	Exemestane (Aromasin) *Tablet*	--	25mg	PA, SP	$128.47	

	Letrozole (Femara) *Tablet*	--	2.5mg	--	$5.00	
Antineoplastic-Histone Deacetylase Inhibitor	Belinostat (Beleodaq) *IV Solution*	--	500 mg	PA, SP	$2,437.20	
	Panobinostat (Farydak) *Capsule*	--	10 mg	PA, SP	$2,137.44	
			20 mg	PA, SP	--	
	RomiDEPsin (Istodax) *IV Solution*	J9315	10 mg	PA, SP	--	
			27.5 mg/5.5 ml	PA, SP	--	
	Vorinostat (Zolinza) *Capsule*	--	100mg	PA, SP	$18,011.52*	
Antineoplastic-Estrogen Receptor Antagonist	*Fulvestrant (Faslodex) Intramuscular injection*	J9395	250mg/5ml	PA, SP	$1,375.50*	
	Selective Estrogen Receptor Modulator (SERM)					
	Tamoxifen (Novadex, Soltamox) *Oral Solution, Tablet*	--	10mg	--	$14.55	
		--	20mg	--	--	
		--	10mg/5ml	--	--	
	Toremifene (Fareston) *Tablet*	--	60mg	NF	$1,287.70	
Angiogenesis Inhibitor	Lenalidomide (Revlimid) *Capsule*	--	2.5mg	PA, SP	--	
			5mg	PA, SP	--	
			10mg	PA, SP	--	
			15mg	PA, SP	--	
			20mg	PA, SP	--	
			25mg	PA, SP	--	
	Pomalidomide (Pomalyst) *Capsule*	--	1 mg	NF	--	
			2 mg	NF	--	
			3 mg	NF	--	
			4 mg	NF	--	
GnRH Agonist	Goserelin Acetate (Zoladex) *Implant*	J9202	3.6mg	PA, SP	--	
			10.8mg	PA, SP	--	
	Histrelin Acetate (Vantas) *Kit*	--	50mg	PA, SP	--	
	Leuprolide Acetate (Eligard) *Syringe*	J9219	7.5mg	PA, SP	--	
			22.5mg	PA, SP	--	
			30mg	PA, SP	--	
			45mg	PA, SP	--	
	Leuprolide Acetate (Lupron Depot) *Syringe Kit*	J1950 (37.5 mg) J9217 (7.5 mg)	7.5mg	PA, SP	--	
			22.5mg	PA, SP	--	
			30mg	PA, SP	--	
	Leuprolide Acetate *Kit*	J9218	1mg/0.2ml	PA, SP	$316.80	
	Triptorelin Pamoate (Trelstar) *Syringe*	J3315 J3316	3.75mg/2ml	PA, SP	--	
			11.25mg/2ml	PA, SP	--	
Antineoplastic Agent, Antimicrotubular	Eribulin (Halaven) *IV*	J9179	1 mg/2 ml	NF	--	
	Taxane Derivative					

	Carbazitaxel (Jevtana) *IV*	--	60 mg/1.5 ml	NF	--	
	Docetaxel (Docefrez) *IV*	J9171	20mg	PA, SP	--	
			20 mg/ml	PA, SP	--	
			20 mg/2 ml	PA, SP	--	
			FNL 20 mg/2	PA, SP	--	
			80 mg	PA, SP	--	
			80 mg/4 ml	PA, SP	--	
			80 mg/8 ml	PA, SP	--	
			FNL 80 mg/8	PA, SP	--	
			160 mg/8 ml	PA, SP	--	
			160 mg/ 16 ml	PA, SP	--	
	Paclitaxel *IV*	J9265	30 mg/5 ml	NF	--	
			100 mg/16.7 ml	NF	--	
			150 mg/25 ml	NF	--	
			300 mg/50 ml	NF	--	
	Paclitaxel Protein-Bound *IV*	J9264	100mg	PA, SP	$3,385.20*	
	Epothilone B Analog					
	Ixabepilone (Ixempra**)** *IV*	J9207	15 mg	PA, SP	$1,778.40	
			45 mg	PA, SP	$5,335.20	
	Vinca Alkaloids					
	Vinblastine Sulfate *IV*	--	1mg/ml	PA, SP	$423.00	
	Vincristine Sulfate (Vincasar PFS) *IV*	--	1mg/ml	PA, SP	$81.00	
	Vincristine Sulfate Liposomal (Marqibo) *IV*	--	5mg/31ml	PA, SP	--	
	Vinorelbine Tartrate (Navelbine) *IV*	J9390	10mg/ml	PA, SP	$2,593.00*	
			50 mg/5 ml	PA, SP	--	
EZH2-Inhibitor, Histone Methyltransferase (HMT) Inhibitor	Tazemetostat (Tazverik) *Tablet*	--	200 mg	PA, SP	--	
Nuclear Export Inhibitor	Selinexor (Xpovio)	--	40 mg once weekly:	PA, SP	--	
		--	60 mg once weekly:	PA, SP	--	
		--	80 mg once weekly:	PA, SP	--	
		--	100 mg once weekly:	PA, SP	--	
		--	40 mg twice weekly:	PA, SP	--	
		--	60 mg twice weekly:	PA, SP	--	
		--	80 mg twice weekly:	PA, SP	--	
Anti-PD1	Pembrolizumab (Keytruda) *IV*	J9271	100 mg/4 ml	--	--	
PARP Inhibitor	Niraparib (Zejula)	--	100 mg	PA, SP	--	

	Capsule					
	Olaparib (Lynparza) *Capsule, Tablet*	--	50 mg caps	PA, SP	--	Capsules and tablets are not interchangeable. Only the tablet forms have FDA indications for breast cancer.
			100 mg tabs	PA, SP	--	
			150 mg tabs	PA, SP	--	
	Talazoparib (Talzenna) *Capsule*	--	0.25 mg	PA, SP	--	
			1 mg	PA, SP	--	
Phosphatidylinositol 3-Kinase Inhibitor	Alpelisib (Piqray) *Tablet*	--	200 mg	PA, SP	--	
			250 mg pack: 200 mg /50 mg	PA, SP	--	
			300 mg pack: 150 mg	PA, SP	--	
Protease inhibitor	**Bortezomib (Velcade)** *Vial*	J9041 J9044	3.5mg	PA, SP	$17,299.30*	
Retinoic Acid Derivative	Bexarotene (Targretin) *Capsule*	--	75mg	PA, SP	$35,800	
	Tretinoin (Vesanoid) *Capsule*	--	10mg	PA, SP	$3,846.55	
Topoisomerase I Inhibitor, Camptothecin	Irinotecan HCl (Camptosar) *IV*	81350	40mg/2ml	PA, SP	--	
			300mg/15ml	PA, SP	--	
	Irinotecan Liposomal (Onivyde) *IV*	81350	43mg/10ml	PA, SP	$13,234.26*	
	Topotecan (Hycamtin) *Capsule, IV*	--	0.25mg Capsules	PA, SP	--	
			1mg Capsules	PA, SP	--	
			IV: 4mg/4mL	PA, SP	--	
Topoisomerase II Inhibitor	**Podophyllotoxin derivative**					
	Etoposide (Etopophos) *Capsule, Vial*	--	PO: 50mg	PA, SP	--	
			IV: 100mg	PA, SP	--	
	Anthracenedione					
	Mitoxantrone *Vial*	J9293	2mg/ml	PA, SP	$121.75*	
	Anthracycline					
	Daunorubicin (Cerubidine) *IV*	XW033B3 XW043B3	5 mg/ml	PA, SP	5 mg/ml	
	Idarubicin (Idamycin) *IV*	--	1mg/ml	PA, SP	$3,057.60	
	Valrubicin (Valstar) *IV*	--	40mg/ml	PA, SP	$6,635.70	
BCR-ABL, Tyrosine Kinase Inhibitor	Bosutinib (Bosulif) *Tablet*		100 mg	NF	--	
			400 mg	NF	--	
			500 mg	NF	--	
	Dasatinib (Sprycel) *Tablet*	--	20mg	PA, SP	--	
			50mg	PA, SP	--	
			70mg	PA, SP	--	
			80mg	PA, SP	--	
			100mg	PA, SP	--	

			140mg	PA, SP	--	
	Imatinib (Gleevec) *Tablet*	--	100mg	PA, SP	--	
			400mg	PA, SP	--	
	Nilotinib (Tasigna) *Tablet*	--	250mg	PA, SP	$12,053.15*	
	Ponatinib (Iclusig) *Tablet*	--	15 mg	NF	--	
			45 mg	NF	--	
Bruton Tyrosine Kinase Inhibitor	Ibrutinib (Imbruvica) *Capsule, Tablet*	--	70 mg capsules	PA, SP	--	
			140 mg capsules	PA, SP	--	
			140 mg tablets	PA, SP	--	
			280 mg tablets	PA, SP	--	
			420 mg tablets	PA, SP	--	
			560 mg tablets	PA, SP	--	
Epidermal Growth Factor Receptor (EGFR) Inhibitor, Tyrosine Kinase Inhibitor	Erlotinib (Tarceva) *Tablet*	--	25mg	PA, SP	--	
			100mg	PA, SP	--	
			150mg	PA, SP	--	
Vascular Endothelial Growth Factor (VEGF) Inhibitor, Tyrosine Kinase Inhibitor	Axitinib (Inlyta) *Tablet*	--	1 mg	PA, SP	--	
			5 mg	PA, SP	--	
	Cabozantinib (Cabometyx) *Tablet, Kit*	--	60 mg daily dose	PA, SP	--	
			100 mg daily dose	PA, SP	--	
			140 mg daily dose	PA, SP	--	
			20 mg	PA, SP	--	
			40 mg	PA, SP	--	
			60 mg	PA, SP	--	
	Lenvatinib (Lenvima) *Capsule*	--	4 mg daily dose	PA, SP	--	
			8 mg daily dose	PA, SP	--	
			10 mg daily dose	PA, SP	--	
			12 mg daily dose	PA, SP	--	
			14 mg daily dose	PA, SP	--	
			18 mg daily dose	PA, SP	--	
			20 mg daily dose	PA, SP	--	
			24 mg daily dose	PA, SP	--	
	Pazopanib (Votrient) *Tablet*	--	200 mg	PA, SP	--	
	Regorafenib (Stivarga) *Tablet*	--	40 mg	PA, SP	--	
	Sorafenib (Nexavar) *Tablet*	C9399 J8999	200mg	PA, SP	$22,404.44*	
	Sunitinib (Sutent) *Capsule*	--	12.5mg	PA, SP	--	
			25mg	PA, SP	--	
			50mg	PA, SP	--	

Janus Kinase Inhibitors	Ruxolitinib (Jakafi) *Tablet*	--	5 mg	PA, SP	--	
			10 mg	PA, SP	--	
			15 mg	PA, SP	--	
			20 mg	PA, SP	--	
			25 mg	PA, SP	--	
Hedgehog Pathway Inhibitors	Vismodegib (Erivedge) *Capsule*	--	150 mg	PA, SP	--	
Proteasome Inhibitors	Carfilzomib (Kyprolis) *IV*	--	10 mg	PA, SP	--	
			30 mg	PA, SP	--	
			60 mg	PA, SP	--	
	Ixazomib (Ninlaro) *Capsule*	C9399 J3490 J8999	2.3 mg	PA, SP		
			3 mg	PA, SP	--	
			4 mg	PA, SP	--	
Tropomyosin Receptor Kinase (TRK) Inhibitor, Tyrosine Kinase Inhibitor	Entrectinib (Rozlytrek) *Capsule*		100 mg	PA, SP	--	
			200 mg	PA, SP	--	
	Larotrectinib (Vitrakvi) *Capsule, oral solution*	--	25 mg	PA, SP	--	
			100 mg	PA, SP	--	
			25 mg/ml	PA, SP	--	
Anaplastic Lymphoma Kinase Inhibitor, Tyrosine Kinase Inhibitor	Alectinib (Alecensa) *Capsule*	J8999 C9399	150 mg	PA, SP	--	
	Brigatinib (Alunbrig) *Tablet, Therapy Pack*	--	30 mg	PA, SP	--	
			90 mg	PA, SP	--	
			180 mg	PA, SP	--	
			90 & 180 mg Therapy pack	PA, SP	--	
	Crizotinib (Xalkori) *Capsule*	J9999	200 mg	PA, SP	--	
			250 mg	PA, SP	--	
	Lorlatinib (Lorbrena) *Tablet*	--	25 mg	PA, SP	--	
			100 mg	PA, SP	--	
FLT3 Inhibitor, Tyrosine Kinase Inhibitor	Midostaurin (Rydapt) *Capsule*	--	25 mg	PA, SP	--	
Tropomyosin Receptor Kinase (TRK) Inhibitor, Tyrosine Kinase Inhibitor	Entrectinib (Rozlytrek) *Capsule*	--	100 mg	PA, SP	--	
			200 mg	PA, SP	--	
	Larotrectinib (Vitrakvi) *Capsule, oral solution*	--	25 mg	PA, SP	--	
			100 mg	PA, SP	--	
			20 mg/ml	PA, SP	--	
Cyclin-Dependent Kinase Inhibitor	Abemaciclib (Verzenio) *Tablet*	--	50 mg	PA, SP	--	
			100 mg	PA, SP	--	
			150 mg	PA, SP	--	
			200 mg	PA, SP	--	
	Palbociclib (Ibrance)	--	75 mg	PA, SP	--	

	Capsule, Tablet		100 mg	PA, SP	--	
			150 mg	PA, SP	--	
	Ribociclib (Kisqali) *Tablet*	--	200 mg	PA, SP	--	
Miscellaneous	Arsenic Trioxide (Trisenox) *IV*	--	10 mg/10 ml	PA, SP	--	
			12 mg/6 ml	PA, SP	--	
	Asparaginase (Erwinaze) *IV*	--	10,000 Unit	PA, SP	$18,237.40*	
	Hydroxyurea (Hydrea) *Capsule*	--	500mg	--	$21.50	
	Megestrol Acetate *Tablet*	--	20mg	--	--	
			40mg	--	--	
	Mitotane (Lysodren) *Tablet*	--	500mg	PA, SP	$2,294.78*	
	Pegaspargase (Oncaspar) *IV*		750 unit/ml	PA, SP	--	
	Trabectedin (Yondelis) *IV*	J9352	1 mg	PA, SP	--	
Chemotherapy Rescue Agents	Filgrastim (Neupogen, Granix, Zarxio) *Syringe, IV*	J1442 Q5101	300mcg/ml	PA, SP	--	
			300mcg/0.5ml	PA, SP	--	
			480mcg/0.8ml	PA, SP	--	
			480mcg/1.6ml	PA, SP	--	
	Peg-Filgrastim (Neulasta) *Syringe*	J2505	6mg/0.6ml	PA, SP	$5,489.94*	
	RomiPLOStim (NPlate) *SQ*	J2796	125 mcg	PA, SP	--	
			250 mcg	PA, SP	--	
			500 mcg	PA, SP	--	
	Sargramostim (Leukin) *IV*	J2820	250 mcg	PA, SP	--	
	Leucovorin Calcium *Tablet*	--	5mg	--	--	
			10mg	--	--	
			15mg	--	--	
			25mg	--	--	

PA = Prior Authorization Required SP = Restricted to Specialty Pharmacy
** Based on standard pricing (AWP or MAC); for weight dosing, used 70kg or 1.73m² to estimate standard dose*
EGFR=Epidermal Growth Factor Receptor VEGF=Vascular Endothelial Growth Factor MEK mitogen-activated extracellular kinase

EVALUATION CRITERIA FOR APPROVAL/EXCEPTION CONSIDERATION

For agents that do not have established prior authorization criteria or agents that are "Non-Formulary," HPSJ will make the determination based on the **National Comprehensive Cancer Network (NCCN) Guidelines** and **Medical Necessity criteria** as described in HPSJ Medical Review Guidelines (UM06)—*see below for details.*

The following general Medical Necessity criteria are used when there are no diagnosis-or procedure-specific criteria applicable to the situation. All criteria below must be met for the service to be considered medically necessary.

1. The services are prescribed by a licensed health care practitioner practicing within the scope of his/her license in the context of his/her treatment of the individual.
2. The services are safe, effective, and consistent with nationally accepted standards of medical practice.
3. The services are not experimental or investigational.
4. The services are individualized, specific, and consistent with the individual's signs, symptoms, history, and diagnosis.
5. The services follow peer reviewed evidence-based literature that support medical necessity. These services are reasonably expected, in a clinically meaningful way, to:
    i. Help restore or maintain the individual's health, or
    ii. Improve or prevent deterioration of the individual's disorder or condition, or
    iii. Delay progression of a disorder or condition characterized by a progressively deteriorating course when that disorder or condition is the focus of treatment for this episode of care.
6. The individual complies with the essential elements of treatment.
7. The services are not primarily for the convenience of the individual, practitioner, caregiver, family, or another party.
8. Services are not being sought as a way to potentially avoid legal proceedings, incarceration, or other legal consequences.
9. The services are not predominantly domiciliary or custodial.
10. No exclusionary criteria are met.

IV Medications—Submitting UM (Medical) Authorization vs. Pharmacy Authorization:
Most IV medications can be covered under both medical and pharmacy benefits—depending the setting of administration. **For IV medications that is to be dispensed through a LTC pharmacy or outpatient pharmacy, please submit a pharmacy authorization**. For all other administration settings (including buy-and-bill), please submit an UM authorization.

How to submit a PHARMACY (RX) prior authorization form for review:
1. Submit request through HPSJ's **Pharmacy Medication Prior Authorization Request** form which can be obtained from www.hpsj.com
2. Include clinic notes documenting diagnosis, past treatment history, and any pertinent laboratory tests
3. Fax both the completed prior authorization form and the clinic documents to HPSJ Pharmacy Department: 209.762.4704.

How to submit a MEDICAL (UM) prior authorization form for review:
1. Submit request through HPSJ's **Medical Authorization Request form** which can be obtained from www.hpsj.com
2. Include clinic notes documenting diagnosis, past treatment history, and any pertinent laboratory tests
3. Fax both the completed prior authorization form and the clinic documents to HPSJ Medical Department: 209.942.6302.

Alkylating Agents
Altretamine (Hexalen),Busulfan (Myleran, Busulfex), Dacarbazine, Procarbazine (Matulane), Temozolomide (Temodar)

Altretamine, Busulfan, Dacarbazine, Procarbazine, Temozolomide:
- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval**: Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Note:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Alkylating Agents : Nitrogen Mustard
Bendamustine (Bendeka, Treanda), Chlorambucil (Leukeran), Cyclophosphamide, Melphalan (Alkeran)

Bendamustine, Chlorambucil, Cyclophosphamide, Melphalan:

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval**: Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Note:** Medication is to be dispensed by HPSJ's designated specialty pharmacy. Injectable vials do not need PA through the medical side.

Alkylating Agents : Estrogen/Nitrogen Mustard
Estramustine (Emcyt)

Estramustine:

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval**: Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Note:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Alkylating Agents : Nitrosurea
Carmustine (BiCNU), Lomustine (Ceenu), Streptozocin (Zanosar)

Carmustine, Lomustine, Streptozocin

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval**: Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Note:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Alkylating Agents : Platinum Analog
Carboplatin (Paraplatin), Cisplatin, Oxaliplatin (Eloxatin)

Carboplatin, Cisplatin, Oxaliplatin:

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval**: Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other**: Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Anti-androgens
Abiraterone Acetate (Zytiga), Apalutamide (Erleada), Bicalutamide (Casodex), Enzalutamide (Xtandi), Nilutamide (Nilandron), Flutamide (Euflex)

Abiraterone Acetate, Apalutamide, Bicalutamide, Enzalutamide, Nilutamide, Flutamide:

- ❒ **Coverage Criteria:** ***Nilutamide, Flutamide*** -PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval**: Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Antineoplastic Antibiotic
Bleomycin Sulfate (Blenoxane), Dactinomycin (Cosmegen), Mitomycin (Mutamycin)

Bleomycin Sulfate, Dactinomycin, Mitomycin:

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None

- ❒ **Required Information for Approval**: Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Note:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Antineoplastic Monoclonal Antibody
Ipilimumab (Yervoy)

Ipilimumab:

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval**: Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other**: Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Anti-HER2: Monoclonal Antibody
Pertuzumab (Perjeta), Trastuzumab (Herceptin, Kajinti, Ogivri, Trazimera), Trastuzumab and Hyaluronidase (Herceptin Hylecta)

Pertuzumab (Perjeta), Trastuzumab (Herceptin, Kajinti, Ogivri, Trazimera):

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes. Do not need PA through the medical side.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.
- ❒ **NF:** Trastuzumab and Hyaluronidase (Herceptin Hylecta)

Anti-HER2: Monoclonal Antibody, Antimicrotubular
Ado-Trastuzumab emtansine (Kadcyla)

Ado-Trastuzumab emtansine:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy. Do not need PA through the medical side.

Anti-HER2: Monoclonal Antibody, Anti-PD-L1
Atezolizumab (Tecentriq), Avelumab (Bavencio), Durvalumab (Imfinzi)

Atezolizumab, Avelumab, Durvalumab:

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy. *Atezolizumab* Do not need PA through the medical side.

Anti-HER2: Monoclonal Antibody, Anti-CD20
Rituximab (Rituxan)

Rituximab:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Anti-HER2: Monoclonal Antibody, Topoisomerase I Inhibitor
Fam-Trastuzumab Deruxtecan (Enhertu)

Fam-Trastuzumab Deruxtecan:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Anti-HER2: Topoisomerase II Inhibitor
Doxorubicin (Adriamycin), EpiRUBicin (Ellence)

Doxorubicin, EpiRUBicin:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Anti-HER2: Monoclonal Antibody, Topoisomerase I & II Inhibitor
Sacituzumab Govitecan (Trodelvy)

Sacituzumab Govitecan:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Anti-HER2: Tyrosine Kinase Inhibitor
Tucatinib (Tukysa)

Tucatinib:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Anti-HER2: Epidermal Growth Factor Receptor (EGFR) Inhibitor, Tyrosine Kinase Inhibitor
Lapatinib (Tykerb), Neratinib (Nerlynx)

Lapatinib, Neratinib:

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Anti-HER2: Combination agents
Pertuzumab, Trastuzumab, and Hyaluronidase (Phesgo)

Pertuzumab:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

- ❒ **NF:** Hyaluronidase (Phesgo)

Anti-CD19/CD3
Blinatumomab(Blincyto)

Blinatumomab:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Anti-CD20
Obinutuzumab (Gazyva)

Obinutuzumab:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy

Anti-CD30
Brentuximab Vedotin (Adcetris)

Brentuximab Vedotin:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy

Anti-CD38
Daratumumab (Darzalex)

Daratumumab:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy

Anti-PD-1
Nivolumab (Opdivo), Pembrolizumab (Keytruda)

Nivolumab, Pembrolizumab:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy

BRAF Kinase Inhibitor
Darbrafenib (Tafinlar), Encorafenib (Braftovi)

Darbrafenib, Encorafenib:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None

- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy

MEK inhibitor
Cobimetinib Fumarate (Cotellic), Trametinib Dimethyl Sulfoxide (Mekinist)

Cobimetinib Fumarate, Trametinib Dimethyl Sulfoxide:

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.
- ❒ **NF:** N/A

mTOR Kinase Inhibitor
Everolimus (Afinitor)

Everolimus :

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Monoclonal Antibody: Vascular Endothelial Growth Factor (VEGF) Inhibitor
Bevacizumab (Avastin, Mvasi, Zirabev)

Bevacizumab:

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Vascular Endothelial Growth Factor Receptor (VEGFR) Inhibitor
Ramucirumab (Cyramza)

Ramucirumab:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy

Monoclonal Antibody: Endothelial Growth Factor (EGFR) Inhibitor
Cetuximab (Erbitux), Necitumumab (Portrazza), Panitumumab (Vectibix)

Cetuximab, Necitumumab, Panitumumab:

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Monoclonal Antibody: Endothelial Growth Factor (EGFR) Inhibitor, DNA Methylation Inhibitor
Azacitidine (Vidaza), Decitabine (Dacogen)

Azacitidine, Decitabine:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.

- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy

Anti-metabolites: Purine Analog
Mercaptopurine (Purinethol)

Mercaptopurine (Purinethol):

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy

Anti-metabolites: Pyrimidine Analog
Capecitabine (Xeloda), Cytarabine (Cytosar), Fluorouracil (Adrucil), Gemcitabine (Gemzar, Infugem),

Capecitabine, Cytarabine, Gemcitabine:

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Anti-metabolites: Pyrimidine Analog, Thymidine Phosphorylase Inhibitor
Trifluridine and Tipiracil (Lonsurf)

Trifluridine and Tipiracil:

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Anti-metabolites: Antifolate
Methotrexate (Trexall, Xatmep, Rasuvo, Otrexup), Pemetrexed (Alimta), Thioguanine (Tabloid)

Methotrexate, Pemetrexed, Thioguanine:

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.
- ❒ **NF:** Methotrexate (Trexall oral tablets, Xatmep oral solution, Rasuvo SQ autoinjection)

Aromatase Inhibitors
Anastrozole (Arimidex), Exemestane (Aromasin), Letrozole (Femara)

Anastrozole, Exemestane, Letrozole:

- ❒ **Coverage Criteria:** PA required for **Exemestane.** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Exemestane is to be dispensed by HPSJ's designated specialty pharmacy.

Histone Deacetylase Inhibitor
Belinostat (Beleodaq), Panobinostat (Farydak), RomiDEPsin (Istodax), Vorinostat (Zolinza)

Belinostat, Panobinostat, RomiDEPsin, Vorinostat (Zolinza):

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Estrogen Receptor Antagonist
Fulvestrant (Faslodex)

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.
- ❒ **NF:** Fulvestrant

Selective Estrogen Receptor Modulator (SERM)
Tamoxifen (Novadex, Soltamox), Toremifene (Fareston)

Tamoxifen (Novadex):

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.
- ❒ **NF:** Tamoxifen solution, Toremifene

Angiogenesis Inhibitor
Lenalidomide (Revlimid), Pomalidomide (Pomalyst)

Lenalidomide, Pomalidomide:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy

GnRH Agonist
Goserelin Acetate (Zoladex), Histrelin Acetate (Vantas), Leuprolide Acetate (Eligard, Lupron), Triptorelin Pamoate (Trelstar)

Goserelin Acetate, Histrelin Acetate, Leuprolide Acetate, Triptorelin Pamoate:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy

Antimicrotubular
Eribulin (Halaven)

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.
- ❒ **NF:** Eribulin (Halaven)

Antimicrotubular: Taxane Derivative
Carbazitaxel (Jevtana), Docetaxel (Docefrez), Paclitaxel, Paclitaxel Protein-Bound

***Docetaxel, Paclitaxel Protein-Bound**:*

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy. All 3 medications do not need PA through the medical side.

Antimicrotubular: Epothilone B Analog
Ixabepilone (Ixempra)

Ixabepilone (Ixempra):

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Antimicrotubular: Vinca Alkaloids
Vinblastine Sulfate, Vincristine Sulfate (Vincasar PFS), Vincristine Sulfate Liposomal (Marqibo), Vinorelbine Tartrate (Navelbine)

Vinblastine Sulfate, Vincristine Sulfate (Vincasar PFS), Vincristine Sulfate Liposomal, Vinorelbine Tartrate (Navelbine):

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

EZH2-Inhibitor, Histone Methyltransferase (HMT) Inhibitor
Tazemetostat (Tazverik)

Tazemetostat:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Nuclear Export Inhibitor
Selinexor (Xpovio)

Selinexor:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

PARP Inhibitor
Niraparib (Zejula), Olaparib (Lynparza), Talazoparib (Talzenna)

Niraparib, Olaparib, Talazoparib:

- ❒ **Coverage Criteria:** PA required. Approval is determined by medical necessity criteria.
- ❒ **Limits:** None

- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Phosphatidylinositol 3-Kinase Inhibitor
Alpelisib (Piqray)

Alpelisib:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Protease inhibitor
Bortezomib (Velcade)

Bortezomib:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Retinoic Acid Derivative
Bexarotene (Targretin), Tretinoin (Vesanoid)

Bexarotene, Tretinoin :

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Topoisomerase I Inhibitor: Camptothecin
Irinotecan HCl (Camptosar), Irinotecan Liposomal (Onivyde), Topotecan (Hycamtin)

Irinotecan HCL, Irinotecan Liposomal, Topotecan:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Topoisomerase II Inhibitor: Podophyllotoxin derivative
Etoposide (Etopophos)

Etoposide:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Topoisomerase II Inhibitor: Anthracenedione
Mitoxantrone

Mitoxantrone:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None

- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Topoisomerase II Inhibitor: Anthracycline
Daunorubicin (Cerubidine), Idarubicin (Idamycin), Valrubicin (Valstar)

Daunorubicin, Idarubicin, Valrubicin:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

BCR-ABL, Tyrosine Kinase Inhibitor
Bosutinib (Bosulif), Dasatinib (Sprycel), Imatinib (Gleevec), Nilotinib (Tasigna), Ponatinib (Iclusig)

Dasatinib, Imatinib, Nilotinib:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Bruton Tyrosine Kinase Inhibitor
Ibrutinib (Imbruvica)

Ibrutinib:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Epidermal Growth Factor Receptor (EGFR) Inhibitor, Tyrosine Kinase Inhibitor
Erlotinib (Tarceva)

Erlotinib:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Vascular Endothelial Growth Factor (VEGF) Inhibitor, Tyrosine Kinase Inhibitor
Axitinib (Inlyta), Cabozantinib (Cabometyx), Lenvatinib (Lenvima), Pazopanib (Votrient), Regorafenib (Stivarga), Sorafenib (Nexavar), Sunitinib (Sutent)

Axitinib, Cabozantinib, Lenvatinib, Pazopanib, Regorafenib, Sorafenib, Sunitinib:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Janus Kinase Inhibitors
Ruxolitinib (Jakafi)

Ruxolitinib:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.

- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Hedgehog Pathway Inhibitors
Vismodegib (Erivedge)

Vismodegib:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Proteasome Inhibitors
Carfilzomib (Kyprolis), Ixazomib (Ninlaro)

Carfilzomib, Ixazomib:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Tropomyosin Receptor Kinase (TRK) Inhibitor, Tyrosine Kinase Inhibitor
Entrectinib (Rozlytrek), Larotrectinib (Vitrakvi)

Entrectinib, Larotrectinib:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Anaplastic Lymphoma Kinase Inhibitor, Tyrosine Kinase Inhibitor
Alectinib (Alecensa), Brigatinib (Alunbrig), Crizotinib (Xalkori), Lorlatinib (Lorbrena)

Alectinib, Brigatinib, Crizotinib, Lorlatinib:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

FLT3 Inhibitor, Tyrosine Kinase Inhibitor
Midostaurin (Rydapt)

Midostaurin:

- ❒ **Coverage Criteria:** PA required, approval is determined by medical necessity criteria.
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Tropomyosin Receptor Kinase (TRK) Inhibitor, Tyrosine Kinase Inhibitor
Entrectinib (Rozlytrek), Larotrectinib (Vitrakvi)

Entrectinib, Larotrectinib:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.

- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Cyclin-Dependent Kinase Inhibitor
Abemaciclib (Verzenio), Palbociclib (Ibrance), Ribociclib (Kisqali)

Abemaciclib, Palbociclib, Ribociclib:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None e
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy.

Miscellaneous
Arsenic Trioxide (Trisenox), Asparaginase (Erwinaze), Hydroxyurea (Hydrea), Megestrol Acetate, Mitotane (Lysodren), Pegaspargase (Oncaspar), Trabectedin (Yondelis)

Arsenic Trioxide, Asparaginase, Hydroxyurea, Megestrol Acetate, Mitotane, Pegaspargase, Trabectedin:

- ❒ **Coverage Criteria:** Approval is determined by medical necessity criteria.
- ❒ **Limits:** None e
- ❒ **Required Information for Approval:** Chart notes documenting the patient's diagnosis, prognosis, lab results, treatment history and outcomes.
- ❒ **Other Notes:** Hydroxyurea and Megestrol do not need PA.

Colony Stimulating Factors
1st line—filgrastim-sndz (Zarxio), peg-filgrastim (Neulasta); 2nd line—filgrastim (Neupogen), tbo-filgrastim (Granix); RomiPLOStim (NPlate), Sargramostim (Leukin)

1st line— filgrastim-sndz (Zarxio), peg-filgrastim (Neulasta), RomiPLOStim, Sargramostim:

- ❒ **Coverage Criteria:** Medical necessity
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** filgrastim-sndz (Zarxio), peg-filgrastim (Neulasta) will be approved based upon medical necessity.
- ❒ **Other Notes:** None

2nd line— filgrastim (Neupogen), tbo-filgrastim (Granix)

- ❒ **Coverage Criteria:** filgrastim (Neupogen), tbo-filgrastim (Granix) are reserved for documentation of treatment failure of a 1st line agent (filgrastim-sndz (Zarxio), peg-filgrastim (Neulasta).
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** Drug refill history showing fill(s) of a 1st line agent
- ❒ **Other Notes:** None

REFERENCES

1. Blackwell K, Semiglazov V, Krasnozhon D, et al. Comparison of EP2006, a filgrastim biosimilar, to the reference: a phase III, randomized, double-blind clinical study in the prevention of severe neutropenia in patients with breast cancer receiving myelosuppressive chemotherapy. Ann Oncol. 2015;26(9):1948-53.
2. NCCN Guidelines & Clinical Resources. https://www.nccn.org/professionals/physician_gls/default.aspx.

REVIEW & EDIT HISTORY

Document Changes	Reference	Date	P&T Chairman
Creation of Policy	HPSJ Coverage Policy – Oncology – Cancer 2016-05.docx	5/2016	Johnathan Yeh, PharmD
Update of Policy	HPSJ Coverage Policy – Oncology – Cancer 2017-05.docx	5/2017	Johnathan Yeh, PharmD
Update of Policy	HPSJ Coverage Policy – Oncology – Cancer 2018-09.docx	9/2018	Johnathan Yeh, PharmD
Update of Policy	HPSJ Coverage Policy – Oncology – Cancer 2019-09.docx	9/2019	Matthew Garrett, PharmD

Update of Policy	HPSJ Coverage Policy – Oncology – Cancer 2019-09.docx	9/2020	Matthew Garrett, PharmD

Note: All changes are approved by the HPSJ P&T Committee before incorporation into the utilization policy