

MEDICATION COVERAGE POLICY

PHARMACY AND THERAPEUTICS ADVISORY COMMITTEE

POLICY	Cancer	LAST REVIEW	12/14/21
THERAPEUTIC CLASS	Oncology	REVIEW HISTORY	9/20, 9/19, 9/18, 5/17,
LOB AFFECTED	Medi-Cal	(MONTH/YEAR)	5/16

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 are 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 12/2021)

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	--	
				20mg		--	
		J9328		100mg		--	
				140mg		--	
			250mg	--			
			280mg	--			
			IV: 100mg	--			
Nitrogen Mustard							

	Bendamustine (Bendeka, Treanda) <i>IV</i>	J9033 (Bendeka)	25 mg	NF	--		
		J9034 (Treanda)	100 mg		--		
	Chlorambucil (Leukeran) <i>Tablet</i>	--	2mg	PA, SP	\$368.89*		
	Cyclophosphamide <i>Capsule</i>	J8530	25mg	PA, SP	\$328.99		
		--	50 mg	PA, SP	--		
	Cyclophosphamide <i>Vial</i>	J9070	500mg	PA, SP	\$854.58		
			1 gram	PA, SP	--		
			2 gram	PA, SP	--		
	Melphalan (Alkeran) <i>Tablet</i>	--	2mg	PA, SP	\$2,335.5*		
	Estrogen/Nitrogen Mustard						
	Estramustine (Emcyt) <i>Capsule</i>	--	140mg	PA, SP	\$3,372.60*		
	Nitrosurea						
	Carmustine (BiCNU) <i>IV</i>	--	100mg	PA, SP	\$3,084.3*		
	Lomustine (Ceenu) <i>Capsule</i>	--	10mg	PA, SP	--		
		--	40mg		--		
		--	100mg		--		
Streptozocin (Zanosar)	--	1gram	PA, SP	\$1,676.00			
Platinum Analog							
Carboplatin (Paraplatin) <i>IV</i>	J9045	600 mg/60 ml	NF	\$43.80			
Cisplatin <i>IV</i>	J9060	50 mg/50 ml	NF	\$12.50			
Oxaliplatin (Eloxatin) <i>IV</i>	J9263	50mg/10ml,	PA, SP	--			
		100mg/20ml		--			
Anti-androgens	Abiraterone Acetate (Yonsa, Zytiga) <i>Tablet</i>	--	125 mg	PA, SP	--		
		--	250 mg		--		
		--	500 mg		--		
	Apalutamide (Erleada) <i>Tablet</i>	--	60 mg	PA, SP	--		
	Bicalutamide (Casodex) <i>Tablet</i>	--	50mg	--	\$8.28		
	Enzalutamide (Xtandi) <i>Capsule</i>	--	40 mg	PA, SP	--		
	Nilutamide (Nilandron) <i>Tablet</i>	--	150mg	PA, SP	\$8,696.34*		
Flutamide (Euflex) <i>Capsule</i>	--	125mg	PA, SP	\$231.61			
Antineoplastic Antibiotic	Bleomycin Sulfate (Blenoxane) <i>IV</i>		15 unit	PA, SP	--		
			30 unit		--		
	Dactinomycin (Cosmegen) <i>IV</i>		0.5 mg	PA, SP	\$3,040.50*		
			5mg	PA, SP	--		

	Mitomycin (Mutamycin) <i>IV</i>		20mg		--	
			40mg		--	
Monoclonal Antibody	Ipilimumab (Yervoy) <i>IV</i>	J9228	50 mg	PA, SP	--	
			200 mg		--	
Anti-HER2	Monoclonal Antibody					
	Pertuzumab (Perjeta) <i>IV</i>	J9306	420mg/14ml	PA, SP	\$18,045.00*	
	Trastuzumab (Herceptin, Kajinti, Ogivri, Trazimera) <i>IV</i>	J9355	150mg	PA, SP	\$9,644.09*	
			420mg	PA, SP	\$9,644.09*	
	Trastuzumab and Hyaluronidase (Herceptin Hylecta) <i>SQ</i>	--	600 mg	NF	--	
	Monoclonal Antibody, Antimicrotubular					
	Ado-Trastuzumab emtansine (Kadcyla) <i>IV</i>	J9354	100 mg	PA, SP	--	
			160 mg	PA, SP	--	
	Monoclonal Antibody, Anti-PD-L1					
	Atezolizumab (Tecentriq) <i>IV</i>	J9022	840 mg/14 ml	PA, SP	--	
			1200 mg/20 mL	PA, SP	\$10,656.65*	
	Avelumab (Bavencio) <i>IV</i>	--	200 mg/10 ml	PA, SP	\$1,859.52*	
	Durvalumab (Imfinzi) <i>IV</i>	--	120mg/2.4ml	PA,SP	--	
			500mg/10ml	PA,SP	--	
	Monoclonal Antibody, Anti-CD20					
	Rituximab (Rituxan) <i>IV</i>	J9312	10mg/ml	PA, SP	\$12,624.69*	10mg/ml
	Rituximab hyaluronidase <i>IV</i>	J9311	10 mg	NF	--	
	Monoclonal Antibody, Topoisomerase I Inhibitor					
	Fam-Trastuzumab Deruxtecan (Enhertu) <i>IV</i>	--	100 mg	PA, SP	--	
	Monoclonal Antibody, Topoisomerase I & II Inhibitor					
	Sacituzumab Govitecan (Trodelvy) <i>IV</i>	--	180 mg	PA, SP	--	
	Topoisomerase II Inhibitor					
	DOXOrubicin (Adriamycin, Myocet) <i>IV</i>	Q2050	2 mg/ml	PA, SP	--	
			50 mg		--	
	EpiRUBicin (Ellence) <i>IV</i>	J9178	50 mg/25 ml	PA, SP	--	
			200 mg/100 ml		--	
	Tyrosine Kinase Inhibitor					
	Tucatinib (Tukysa) <i>Tablet</i>	--	50 mg	PA, SP	\$16,560	
150 mg			PA, SP	\$11,100		
Epidermal Growth Factor Receptor (EGFR) Inhibitor, Tyrosine Kinase Inhibitor						
Lapatinib (Tykerb) <i>Tablet</i>	--	250mg	PA, SP	\$4,852.90*		
Neratinib (Nerlynx) <i>Tablet</i>	--	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	--	
	Daratumumab and Hyaluronidase-fihj (Darzalex Faspro) SQ	J9144	Daratumumab 1,800 mg and hyaluronidase-fihj 30,000 units per 15 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	20 mg	PA, SP	\$6,677.33*	
		C9399				
	Trametinib Dimethyl Sulfoxide (Mekinist) Tablet	C9399	0.5mg	PA, SP	--	
		J3490 J8999	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 (Erbix) 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) <i>IV</i>	J9025	100 mg	PA, SP	--			
Decitabine (Dacogen) <i>IV</i>	J0894	50 mg	PA, SP	--			
Purine Analog							
Mercaptopurine (Purinethol)	--	50 mg	--	--			
Pyrimidine Analog							
Capecitabine (Xeloda) <i>Tablet</i>	--	150 mg	PA, SP	\$1,552.78*			
		500 mg	PA, SP	--			
Cytarabine (Cytosar) <i>IV</i>	XW033B3	20 mg /ml	PA, SP	--			
	XW043B3	100 mg/ml	PA, SP	--			
Fluorouracil (Adrucil) <i>IV</i>	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) <i>Cream, Solution</i>	--	Cream: 0.05%	--	--			
		Cream 0.1%	--	--			
		Cream: 0.5%	--	--			
		Solution: 0.2%	--	--			
		Solution 0.5%	--	--			
Gemcitabine (Gemzar, Infugem) <i>IV</i>	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						
Trifluridine and Tipiracil (Lonsurf) Tablet	--	15-16.4 mg	PA, SP	--		
		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) <i>IV</i>	J9179	1 mg/2 ml	NF	--	
	Taxane Derivative					
	Carbazitaxel (Jevtana) <i>IV</i>	--	60 mg/1.5 ml	NF	--	
	Docetaxel (Docefrez) <i>IV</i>	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 <i>IV</i>	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 <i>IV</i>	J9264	100mg	PA, SP	\$3,385.20*	
	Epothilone B Analog					
	Ixabepilone (Ixempra) <i>IV</i>	J9207	15 mg	PA, SP	\$1,778.40	
45 mg			PA, SP	\$5,335.20		
Vinca Alkaloids						
Vinblastine Sulfate <i>IV</i>	--	1mg/ml	PA, SP	\$423.00		
Vincristine Sulfate (Vincasar PFS) <i>IV</i>	--	1mg/ml	PA, SP	\$81.00		
Vincristine Sulfate Liposomal (Marqibo) <i>IV</i>	--	5mg/31ml	PA, SP	--		
Vinorelbine Tartrate (Navelbine) <i>IV</i>	J9390	10mg/ml	PA, SP	\$2,593.00*		
		50 mg/5 ml	PA, SP	--		
EZH2-Inhibitor, Histone Methyltransferase (HMT) Inhibitor	Tazemetostat (Tazverik) <i>Tablet</i>	--	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) <i>IV</i>	J9271	100 mg/4 ml	--	--	
PARP Inhibitor	Niraparib (Zejula) <i>Capsule</i>	--	100 mg	PA, SP	--	Capsules and tablets are not interchangeable. Only the tablet forms have FDA indications for breast cancer.
	Olaparib (Lynparza) <i>Capsule, Tablet</i>	--	50 mg caps	PA, SP	--	
			100 mg tabs	PA, SP	--	
			150 mg tabs	PA, SP	--	
	Talazoparib (Talzenna) <i>Capsule</i>	--	0.25 mg	PA, SP	--	
1 mg			PA, SP	--		
Phosphatidylinositol 3-Kinase Inhibitor	Alpelisib (Piqray) <i>Tablet</i>	--	200 mg	PA, SP	--	
			250 mg pack: 200 mg /50 mg	PA, SP	--	
			300 mg pack: 150 mg	PA, SP	--	
Protease inhibitor	Bortezomib (Velcade) <i>Vial</i>	J9041 J9044	3.5mg	PA, SP	\$17,299.30*	
Retinoic Acid Derivative	Bexarotene (Targretin) <i>Capsule</i>	--	75mg	PA, SP	\$35,800	
	Tretinoin (Vesanoid) <i>Capsule</i>	--	10mg	PA, SP	\$3,846.55	
Topoisomerase I Inhibitor, Camptothecin	Irinotecan HCl (Camptosar) <i>IV</i>	81350	40mg/2ml	PA, SP	--	
			300mg/15ml	PA, SP	--	
	Irinotecan Liposomal (Onivyde) <i>IV</i>	81350	43mg/10ml	PA, SP	\$13,234.26*	
	Topotecan (Hycamtin) <i>Capsule, IV</i>	--	0.25mg Capsules	PA, SP	--	
			1mg Capsules	PA, SP	--	
			IV: 4mg/4mL	PA, SP	--	
Topoisomerase II Inhibitor	Podophyllotoxin derivative					
	Etoposide (Etopophos) <i>Capsule, Vial</i>	--	PO: 50mg	PA, SP	--	
			IV: 100mg	PA, SP	--	
	Anthracenedione					
	Mitoxantrone <i>Vial</i>	J9293	2mg/ml	PA, SP	\$121.75*	
	Anthracycline					
	Daunorubicin (Cerubidine) <i>IV</i>	XW033B3 XW043B3	5 mg/ml	PA, SP	5 mg/ml	
	Idarubicin (Idamycin) <i>IV</i>	--	1mg/ml	PA, SP	\$3,057.60	
	Valrubicin (Valstar) <i>IV</i>	--	40mg/ml	PA, SP	\$6,635.70	
BCR-ABL, Tyrosine Kinase Inhibitor	Bosutinib (Bosulif) <i>Tablet</i>	--	100 mg	NF	--	
			400 mg	NF	--	
			500 mg	NF	--	
	Dasatinib (Sprycel) <i>Tablet</i>	--	20mg	PA, SP	--	
			50mg	PA, SP	--	

			70mg	PA, SP	--	
			80mg	PA, SP	--	
			100mg	PA, SP	--	
			140mg	PA, SP	--	
	Imatinib (Gleevec) <i>Tablet</i>	--	100mg	PA, SP	--	
			400mg	PA, SP	--	
	Nilotinib (Tasigna) <i>Tablet</i>	--	250mg	PA, SP	\$12,053.15*	
	Ponatinib (Iclusig) <i>Tablet</i>	--	15 mg	NF	--	
			45 mg	NF	--	
Bruton Tyrosine Kinase Inhibitor	Ibrutinib (Imbruvica) <i>Capsule, Tablet</i>	--	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) <i>Tablet</i>	--	25mg	PA, SP	--	
			100mg	PA, SP	--	
			150mg	PA, SP	--	
Vascular Endothelial Growth Factor (VEGF) Inhibitor, Tyrosine Kinase Inhibitor	Axitinib (Inlyta) <i>Tablet</i>	--	1 mg	PA, SP	--	
			5 mg	PA, SP	--	
	Cabozantinib (Cabometyx) <i>Tablet, Kit</i>	--	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) <i>Capsule</i>	--	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) <i>Tablet</i>	--	200 mg	PA, SP	--	
	Regorafenib (Stivarga) <i>Tablet</i>	--	40 mg	PA, SP	--	
	Sorafenib (Nexavar) <i>Tablet</i>	C9399 J8999	200mg	PA, SP	\$22,404.44*	

	Sunitinib (Sutent) <i>Capsule</i>	--	12.5mg	PA, SP	--	
			25mg	PA, SP	--	
			50mg	PA, SP	--	
Janus Kinase Inhibitors	Ruxolitinib (Jakafi) <i>Tablet</i>	--	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) <i>Capsule</i>	--	150 mg	PA, SP	--	
Proteasome Inhibitors	Carfilzomib (Kyprolis) <i>IV</i>	--	10 mg	PA, SP	--	
			30 mg	PA, SP	--	
			60 mg	PA, SP	--	
	Ixazomib (Ninlaro) <i>Capsule</i>	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) <i>Capsule</i>		100 mg	PA, SP	--	
			200 mg	PA, SP	--	
	Larotrectinib (Vitrakvi) <i>Capsule, oral solution</i>	--	25 mg	PA, SP	--	
			100 mg	PA, SP	--	
			25 mg/ml	PA, SP	--	
Anaplastic Lymphoma Kinase Inhibitor, Tyrosine Kinase Inhibitor	Alectinib (Alecensa) <i>Capsule</i>	J8999 C9399	150 mg	PA, SP	--	
	Brigatinib (Alunbrig) <i>Tablet, Therapy Pack</i>	--	30 mg	PA, SP	--	
			90 mg	PA, SP	--	
			180 mg	PA, SP	--	
			90 & 180 mg Therapy pack	PA, SP	--	
	Crizotinib (Xalkori) <i>Capsule</i>	J9999	200 mg	PA, SP	--	
			250 mg	PA, SP	--	
	Lorlatinib (Lorbrena) <i>Tablet</i>	--	25 mg	PA, SP	--	
100 mg			PA, SP	--		
FLT3 Inhibitor, Tyrosine Kinase Inhibitor	Midostaurin (Rydapt) <i>Capsule</i>	--	25 mg	PA, SP	--	
Tropomyosin Receptor Kinase (TRK) Inhibitor, Tyrosine Kinase Inhibitor	Entrectinib (Rozlytrek) <i>Capsule</i>	--	100 mg	PA, SP	--	
			200 mg	PA, SP	--	
	Larotrectinib (Vitrakvi) <i>Capsule, oral solution</i>	--	25 mg	PA, SP	--	
			100 mg	PA, SP	--	
			20 mg/ml	PA, SP	--	
Cyclin-Dependent Kinase Inhibitor	Abemaciclib (Verzenio) <i>Tablet</i>	--	50 mg	PA, SP	--	
			100 mg	PA, SP	--	

			150 mg	PA, SP	--	
			200 mg	PA, SP	--	
	Palbociclib (Ibrance) <i>Capsule, Tablet</i>	--	75 mg	PA, SP	--	
			100 mg	PA, SP	--	
			150 mg	PA, SP	--	
	Ribociclib (Kisqali) <i>Tablet</i>	--	200 mg	PA, SP	--	
Miscellaneous	Arsenic Trioxide (Trisenox) <i>IV</i>	--	10 mg/10 ml	PA, SP	--	
			12 mg/6 ml	PA, SP	--	
	Asparaginase (Erwinaze) <i>IV</i>	--	10,000 Unit	PA, SP	\$18,237.40*	
	Hydroxyurea (Hydrea) <i>Capsule</i>	--	500mg	--	\$21.50	
	Megestrol Acetate <i>Tablet</i>	--	20mg	--	--	
			40mg	--	--	
	Mitotane (Lysodren) <i>Tablet</i>	--	500mg	PA, SP	\$2,294.78*	
	Pegaspargase (Oncaspar) <i>IV</i>		750 unit/ml	PA, SP	--	
Trabectedin (Yondelis) <i>IV</i>	J9352	1 mg	PA, SP	--		
Chemotherapy Rescue Agents	Pegfilgrastim-jmdb (Fulphila) <i>Syringe</i>	Q5108	6mg/0.6mL	PA, SP	--	
	Pegfilgrastim-cbqv (Udenyca) <i>Syringe</i>	Q5111	6mg/0.6mL	PA, SP	--	
	Pegfilgrastim (Neulasta, Neulasta Onpro) <i>Syringe</i>	J2506	6mg/0.6ml	PA, SP	--	
	Filgrastim-sndz (Zarxio) <i>Syringe</i>	Q5101	300 mcg/0.5 mL	PA, SP	--	
	Tbo-filgrastim (Granix) <i>Syringe</i>	J1447	300mcg/0.5mL, 480mcg/0.8mL	PA, SP	--	
	Filgrastim-aafi (Nivestym) <i>IV, Syringe</i>	Q5110	300 mcg/mL, 480 mcg/1.6 mL, 300mcg/0.5mL, 480mcg/0.8mL	PA, SP	--	
	Sargramostim (Leukin) <i>IV</i>	J2820	250 mcg	PA, SP	--	
	Filgrastim (Neupogen) <i>Syringe</i>	J1442	300mcg/0.5mL, 480mcg/0.8mL	PA, SP	--	Reserved for documentation of treatment failure of a 1st line short-acting G-CSF: filgrastim-sndz (Zarxio), tbo-filgrastim (Granix), or

						filgrastim-aafi (Nivestym).
	Pegfilgrastim-bmez (Ziextenzo) Syringe	Q5120	6mg/0.6mL	PA, SP	--	Reserved for documentation of treatment failure of a 1st line long-acting G-CSF: peg-filgrastim (Neulasta, Neulasta Onpro), pegfilgrastim-jmdb (Fulphila), or pegfilgrastim-cbqv (Udenyca).
	Pegfilgrastim-apgf (Nyvepria) Syringe	Q5122	6mg/0.6mL	PA, SP	--	
	Leucovorin Calcium Tablet	--	5mg	--	--	
			10mg	--	--	
			15mg	--	--	
			25mg	--	--	
<i>PA = Prior Authorization Required SP = Restricted to Specialty Pharmacy</i> <i>* Based on standard pricing (AWP or MAC); for weight dosing, used 70kg or 1.73m² to estimate standard dose</i> <i>EGFR=Epidermal Growth Factor Receptor VEGF=Vascular Endothelial Growth Factor MEK mitogen-activated extracellular kinase</i>						

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 on the setting of administration. **For IV medications that is to be dispensed through an LTC pharmacy or**

outpatient pharmacy, please submit a pharmacy authorization. For all other administration settings (including buy-and-bill), please submit a 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.

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.
- 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.

Anti-HER2: Monoclonal Antibody, Anti-PD-L1

<i>Atezolizumab (Tecentriq), Avelumab (Bavencio), Durvalumab (Imfinzi)</i>
--

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.

Anti-HER2: Monoclonal Antibody, Anti-CD20
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<i>Rituximab (Rituxan)</i>

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
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<i>Fam-Trastuzumab Deruxtecan (Enhertu)</i>

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
--

<i>Doxorubicin (Adriamycin), EpiRUBicin (Ellence)</i>

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

<i>Sacituzumab Govitecan (Trodelvy)</i>

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

<i>Tucatinib (Tukysa)</i>

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 and Hyaluronidase-fihj (Darzalex Faspro)

Daratumumab, Daratumumab and Hyaluronidase-fihj:

- 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 (Erbix), 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. Note Paclitaxel does not need PA on the medical benefit.

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
- 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
- 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, Neulasta Onpro), tbo-filgrastim (Granix), filgrastim-aafi (Nivestym), pegfilgrastim-jmdb (Fulphila), pegfilgrastim-cbqv (Udenyca), Sargramostim
2nd line— filgrastim (Neupogen), pegfilgrastim-bmez (Ziextenzo), pegfilgrastim-apgf (Nyvepria)

1st line— filgrastim-sndz (Zarxio), peg-filgrastim (Neulasta, Neulasta Onpro), tbo-filgrastim (Granix), filgrastim-aafi (Nivestym), pegfilgrastim-jmdb (Fulphila), pegfilgrastim-cbqv (Udenyca), Sargramostim

- Coverage Criteria:** Approval is determined by medical necessity criteria.
- Limits:** None.
- Required Information for Approval:** Chart notes documenting the patient's diagnosis and lab results.
- Other Notes:** None.

2nd line— filgrastim (Neupogen)

- Coverage Criteria:** Reserved for documentation of treatment failure of a 1st line short-acting G-CSF: filgrastim-sndz (Zarxio), tbo-filgrastim (Granix), or filgrastim-aafi (Nivestym).
- Limits:** None.
- Required Information for Approval:** Drug refill history showing fill(s) of a 1st line agent.
- Other Notes:** None.

2nd line— pegfilgrastim-bmez (Ziextenzo), pegfilgrastim-apgf (Nyvepria)

- Coverage Criteria:** Reserved for documentation of treatment failure of a 1st line long-acting G-CSF: peg-filgrastim (Neulasta, Neulasta Onpro), pegfilgrastim-jmdb (Fulphila), or pegfilgrastim-cbqv (Udenyca).
- Limits:** None.
- Required Information for Approval:** Drug refill history showing fill(s) of a 1st line agent.
- Other Notes:** None.

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☒ 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 2020-09.docx	9/2020	Matthew Garrett, PharmD
Update of Policy	HPSJ Coverage Policy – Oncology – Cancer 2021-12.docx	12/2021	Matthew Garrett, PharmD

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