

PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Iclusig Prior Authorization Policy

- Iclusig® (ponatinib tablets – ARIAD/Takeda)

REVIEW DATE: 03/27/2024; selected revision 06/05/2024

OVERVIEW

Iclusig, a tyrosine kinase inhibitor (TKI), is indicated for the following uses in adults:¹

- **Philadelphia chromosome-positive (Ph+) acute lymphoblastic leukemia (ALL):**
 - Newly diagnosed in combination with chemotherapy.
 - For whom no other TKIs are indicated as monotherapy.
 - T315I-positive as monotherapy.
- **Chronic myeloid leukemia (CML):**
 - Chronic phase, with resistance or intolerance to at least two prior TKIs.
 - Accelerated phase or blast phase for whom no other kinase inhibitors are indicated.
 - T315I-positive (chronic phase, accelerated phase, or blast phase).

A limitation of use is that Iclusig is not indicated and is not recommended for the treatment of patients with newly diagnosed chronic phase CML.¹

The indication of Ph+ ALL in newly diagnosed patients in combination with chemotherapy is approved under accelerated approval based on minimal residual disease (MRD)-negative complete remission (CR) at the end of induction. Continued approval for this indication may be contingent upon verification of clinical benefit in a confirmatory trial(s).¹

Guidelines

Iclusig is addressed in guidelines from National Comprehensive Cancer Network (NCCN):²⁻⁴

- **ALL:** NCCN guidelines (version 4.2023 – February 5, 2024) [adults and adolescent young adults] recommend Iclusig as a treatment option for patients with the T315I mutation and/or for patients for whom no other TKI is indicated (category 2A).² Iclusig is also recommended in combination with various regimens used for induction or consolidation therapy for Ph+ ALL during frontline therapy or for relapsed/refractory therapy if not previously given (category 2A).
- **CML:** NCCN guidelines (version 2.2024 – December 5, 2023) recommend Iclusig as an option for patients with a T315I mutation and/or chronic phase CML with resistance or intolerance to at least two prior TKIs or for patients with accelerated-phase CML or blast-phase CML for whom no other TKI is indicated (category 2A).³
- **Gastrointestinal Stromal Tumor (GIST):** NCCN guidelines (version 1.2024 – March 8, 2024) recommend Iclusig as “Useful in Certain Circumstances” after failure on approved therapies (category 2A); the guidelines state that Iclusig has demonstrated activity in advanced GIST, particularly in patients with *KIT* exon 11 mutant disease.⁴ Imatinib is a preferred regimen for first-line therapy (category 1) for sensitive mutations (excluding platelet-derived growth factor receptor alpha [*PDGFRA*] exon 18 mutations that are insensitive to imatinib including D842V mutation). Avvakit® (avapritinib tablets) is also a preferred regimen (category 2A) for GIST with *PDGFRA* exon 18 mutations that are insensitive to imatinib, including the *PDGFRA* D842V mutation. Second-line therapies include sunitinib as “preferred” (category 1) and Sprycel as “other recommended regimen” (category 2A). Stivarga® (regorafenib tablets) is a “preferred” third-line therapy (category 1). Qinlock® (ripretinib tablets) is a “preferred” fourth-line therapy (category 1).

03/27/2024

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- **Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions:** NCCN guidelines (version 1.2024 – December 21, 2023) recommend Iclusig for *ABL1* and *FGFR1* rearrangements in chronic phase or blast phase as “Other Recommended Regimens” (category 2A).⁵ It is also recommended as treatment in combination with ALL- or acute myeloid leukemia-type induction chemotherapy followed by allogeneic hematopoietic stem cell transplantation (HSCT) [if eligible] for lymphoid, myeloid or mixed lineage neoplasms with eosinophilia and *ABL1* and *FGFR1* rearrangements in blast phase (category 2A).

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Iclusig. All approvals are provided for the duration noted below.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Iclusig is recommended in those who meet one of the following criteria:

FDA-Approved Indications

- 1. Acute Lymphoblastic Leukemia.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
 - A) Patient is ≥ 15 years of age; AND
 - B) Patient has Philadelphia chromosome-positive acute lymphoblastic leukemia; AND
 - C) Patient meets ONE of the following (i, ii, or iii):
 - i. The medication will be used in combination with chemotherapy; OR
 - ii. The acute lymphoblastic leukemia is T315I-positive; OR
 - iii. Patient has tried at least one other tyrosine kinase inhibitor that is used for Philadelphia chromosome-positive acute lymphoblastic leukemia.
Note: Examples include imatinib and dasatinib products (Sprycel or Phyrago).
- 2. Chronic Myeloid Leukemia (CML).** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
 - A) Patient is ≥ 18 years of age; AND
 - B) Patient has Philadelphia chromosome-positive chronic myeloid leukemia; AND
 - C) Patient meets ONE of the following (i, ii or iii):
 - i. The chronic myeloid leukemia is T315I-positive, OR
 - ii. Patient has tried at least two other tyrosine kinase inhibitors indicated for use in Philadelphia chromosome-positive chronic myeloid leukemia; OR
Note: Examples include imatinib, dasatinib products (Sprycel or Phyrago), and Tasigna (nilotinib capsules).
 - iii. Patient meets BOTH of the following (a and b):
 - a) Patient has accelerated-phase CML or blast-phase CML; AND
 - b) No other tyrosine kinase inhibitor is indicated.

Other Uses with Supportive Evidence

3. **Gastrointestinal Stromal Tumor.** Approve for 1 year if the patient meets BOTH of the following (A and B):
 - A) Patient is ≥ 18 years of age; AND
 - B) Patient has tried each of the following (i, ii, iii, and iv):
 - i. One of imatinib or Ayvakit (avapritinib tablets); AND
 - ii. One of sunitinib or Sprycel (dasatinib tablets); AND
 - iii. Stivarga (regorafenib tablets); AND
 - iv. Qinlock (ripretinib tablets).

4. **Myeloid/Lymphoid Neoplasms with Eosinophilia.** Approve for 1 year if the patient meets BOTH of the following (A and B):
 - A) Patient is ≥ 18 years of age; AND
 - B) Patient meets ONE of the following (i or ii):
 - i. The tumor has an *ABL1* rearrangement; OR
 - ii. The tumor has an *FGFR1* rearrangement.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Iclusig is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Iclusig® tablets [prescribing information]. Lexington, MA: ARIAD/Takeda; March 2024.
2. The NCCN Acute Lymphoblastic Leukemia Clinical Practice Guidelines in Oncology (version 4.2023 – February 5, 2024). © 2024 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on March 21, 2024.
3. The NCCN Chronic Myeloid Leukemia Clinical Practice Guidelines in Oncology (version 2.2024 – December 5, 2023). © 2023 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on March 21, 2024.
4. The NCCN Gastrointestinal Stromal Tumors Guidelines in Oncology (version 1.2024 – March 8, 2024). © 2024 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on March 21, 2024.
5. The NCCN Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions Clinical Practice Guidelines in Oncology (version 1.2024 – December 21, 2023). © 2023 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on March 21, 2024.

