Reference number(s)
2172-A

SPECIALTY GUIDELINE MANAGEMENT

GLEEVEC (imatinib mesylate)
imatinib mesylate (generic)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications
1. Newly diagnosed adult and pediatric patients with Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase
2. Patients with Ph+ CML in blast crisis, accelerated phase, or in chronic phase after failure of interferon-alpha therapy
3. Adult patients with relapsed or refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL)
4. Pediatric patients with newly diagnosed Ph+ ALL in combination with chemotherapy
5. Adult patients with myelodysplastic/myeloproliferative diseases (MDS/MPD) associated with PDGFR (platelet-derived growth factor receptor) gene re-arrangements
6. Adult patients with aggressive systemic mastocytosis without the D816V c-Kit mutation or with c-Kit mutational status unknown
7. Adult patients with hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL) who have the FIP1L1-PDGFRα fusion kinase (mutational analysis or FISH demonstration of CHIC2 allele deletion) and for patients with HES and/or CEL who are FIP1L1-PDGFRα fusion kinase negative or unknown
8. Adult patients with unresectable, recurrent and/or metastatic dermatofibrosarcoma protuberans (DFSP)
9. Patients with Kit (CD117) positive unresectable and/or metastatic malignant gastrointestinal stromal tumors (GIST)
10. Adjuvant treatment of adult patients following complete gross resection of Kit (CD117) positive GIST

B. Compendial Uses
1. Primary treatment of advanced phase CML (accelerated phase or blast phase)
2. Follow-up therapy for CML patients after hematopoietic stem cell transplant (HSCT)
3. Induction/consolidation and maintenance therapy for Ph+ ALL/LL
4. GIST
5. Desmoid tumors
6. Pigmented villonodular synovitis/tenosynovial giant cell tumor
7. Recurrent chordoma
8. Metastatic or unresectable C-Kit mutated melanoma as second-line or subsequent therapy
9. Kaposi sarcoma that has progressed on or not responded to first-line systemic therapy
10. Chronic myelomonocytic leukemia
11. Chronic graft versus host disease
12. Relapsed or refractory pediatric T-cell ALL/LL with ABL-class translocation
13. Myeloid/lymphoid neoplasms with eosinophilia and ABL1 rearrangement in chronic phase

14. Lymphoid, myeloid or mixed lineage neoplasms with eosinophilia and ABL1 rearrangement in blast phase
15. Myeloid/lymphoid neoplasms with eosinophilia and the FIP1L1-PDGFRA or PDGFRB rearrangement in chronic phase or blast phase
16. Aggressive Systemic Mastocytosis (ASM)

All other indications are considered experimental/investigational and not medically necessary.

II. REQUIRED DOCUMENTATION

The following information is necessary to initiate the prior authorization review:
1. For treatment of CML or Ph+ ALL/LL: results of cytogenetic and/or molecular testing for detection of the Ph chromosome or the BCR-ABL gene.
2. For treatment of T-cell ALL/LL: results of cytogenetic and/or molecular testing confirming ABL-class translocation
3. For treatment of MDS/MPD and CMML: results of molecular testing or analysis confirming PDGFR gene rearrangement
4. For the treatment of ASM: results of molecular testing or analysis for D816V c-KIT mutation and FIP1L1-PDGFRA fusion gene (where applicable)
5. For treatment of melanoma: results of molecular testing or analysis confirming c-KIT mutation
6. For treatment of myeloid and/or lymphoid neoplasms with eosinophilia: results of testing or analysis confirming ABL1, FIP1L1-PDGFRA, or PDGFRB rearrangement

III. CRITERIA FOR INITIAL APPROVAL

A. Chronic Myeloid Leukemia (CML)
Authorization of 7 months may be granted for treatment of CML that has been confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing when the member did not fail (other than due to intolerance) prior therapy with a TKI (e.g., dasatinib, nilotinib, bosutinib, ponatinib).

B. Acute Lymphoblastic Leukemia (ALL)/Lymphoblastic Lymphoma (LL)
Authorization of 12 months may be granted for treatment of ALL or LL when any of the following criteria is met:
1. The member has Ph+ ALL or LL that has been confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing
2. The member has T- cell ALL or LL with ABL-class translocation that has been confirmed by cytogenetic and/or molecular testing and the disease is relapsed or refractory

C. Gastrointestinal Stromal Tumor (GIST), Desmoid Tumors, Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor (PVNS/TGCT), Hypereosinophilic Syndrome/Chronic Eosinophilic Leukemia (HES/CEL), Dermatofibrosarcoma Protuberans (DFSP), Chordoma
Authorization of 12 months may be granted for treatment of GIST, desmoid tumors, PVNS/TGCT, HES/CEL, DFSP, or recurrent chordoma.

D. Myelodysplastic Syndromes/Myeloproliferative Diseases (MDS/MPD) and Chronic Myelomonocytic Leukemia (CMML)
Authorization of 12 months may be granted for treatment of MDS/MPD or CMML when the member's disease is associated with PDGFR (platelet-derived growth factor receptor) gene rearrangements

E. Aggressive Systemic Mastocytosis (ASM)
Authorization of 12 months may be granted for treatment of ASM when any of the following criteria is met:
1. D816V c-KIT mutation is negative
2. D816V c-KIT mutation status is unknown
3. Well-differentiated systemic mastocytosis (WDSM)
4. Eosinophilia is present with FIP1L1-PDGFRA fusion gene

F. Melanoma
Authorization of 12 months may be granted for treatment of metastatic or unresectable c-KIT mutation-positive melanoma when the requested medication is used as a single agent and as second-line or subsequent therapy.

G. Kaposi Sarcoma
Authorization of 12 months may be granted for treatment of Kaposi sarcoma when the requested medication is used as subsequent therapy as a single agent or in combination with antiretroviral therapy.

H. Chronic Graft-Versus-Host Disease (cGVHD)
Authorization of 12 months may be granted for treatment of cGVHD when the requested medication is used as subsequent therapy in combination with systemic corticosteroids.

I. Myeloid/Lymphoid Neoplasms with Eosinophilia
Authorization of 12 months may be granted for treatment of myeloid and/or lymphoid neoplasms with eosinophilia and ABL1, FIP1L1-PDGFRA, or PDGFRB rearrangement in the chronic phase or blast phase.

IV. CONTINUATION OF THERAPY

A. CML
Authorization may be granted for continued treatment of CML that has been confirmed by detection of Ph chromosome or BCR-ABL gene by cytogenetic and/ or molecular testing when either of the following criteria is met:
1. Authorization of 12 months may be granted when any of the following criteria is met:
   a. BCR-ABL1 is less than or equal to 10% and there is no evidence of disease progression or unacceptable toxicity while on the current regimen for members who have been receiving the requested medication for 6 months or greater
   b. Member has received HSCT when there is no evidence of disease progression or unacceptable toxicity while on the current regimen
2. Authorization of up to 7 months may be granted when the member has completed less than 6 months of therapy with the requested medication.

B. Acute Lymphoblastic Leukemia or Lymphoblastic Lymphoma (ALL/LL)
Authorization of 12 months may be granted for continued treatment of ALL or LL when there is no evidence of unacceptable toxicity or disease progression while on the current regimen and either of the following criteria is met:
1. The member has Ph+ ALL/LL that has been confirmed by detection of Ph chromosome or BCR-ABL gene by cytogenetic and/ or molecular testing.
2. The member has T-cell ALL/LL with ABL-class translocation that has been confirmed by cytogenetic and/or molecular testing.

C. Desmoid Tumors, PVNS/TGCT, HES/CEL, DFSP, Chordoma, MDS/MPD, CMML, ASM, Melanoma, Kaposi sarcoma, cGVHD, or Myeloid/Lymphoid Neoplasms with Eosinophilia
Authorization of 12 months may be granted for continued treatment of desmoid tumors, PVNS/TGCT, HES/CEL, DFSP, recurrent chordoma, MDS/MPD, CMML, ASM, metastatic or unresectable melanoma, Kaposi sarcoma, cGVHD, or myeloid/lymphoid neoplasms with eosinophilia when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

D. GIST
Authorization of 12 months may be granted for continued treatment of GIST when the member is receiving clinical benefit and there is no evidence of unacceptable toxicity while on the current regimen.

V. REFERENCES

1. Gleevec [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; August 2020.
2. imatinib [package insert]. Cranbury, NJ: Sun Pharmaceuticals Industries, Inc.; August 2020.
3. The NCCN Drugs & Biologics Compendium® © 2021 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed April 28, 2021.
4. NCCN Clinical Practice Guidelines in Oncology® Acute Lymphoblastic Leukemia (Version 2.2020). © 2020 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed March 29, 2021.
5. NCCN Clinical Practice Guidelines in Oncology® Pediatric Acute Lymphoblastic Leukemia (ALL) (Version 2.2021). © 2020 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed March 29, 2021.