MEDICATION POLICY:
Bosulif®

Generic Name: Bosutinib

Therapeutic Class or Brand Name: Bosulif®

Applicable Drugs (if Therapeutic Class): N/A

Preferred: N/A

Non-preferred: N/A

Date of Origin: 2/1/2013

Date Last Reviewed / Revised: 10/19/2022

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I through V are met)

I. Documented diagnosis of one of the following conditions A to C and must meet criteria listed under applicable diagnosis:

   A. Documented diagnosis of chronic, accelerated, or blast phase Chronic Myelogenous Leukemia (CML).

      1. Documentation that the patient's CML is Philadelphia chromosome-positive (Ph+).
      2. Documented trial and failure of, intolerance to, or contraindication to, one of the following other tyrosine kinase inhibitor (TKI) therapies for CML: dasatinib (Sprycel®), imatinib (Gleevec®), nilotinib (Tasigna®), or ponatinib (Iclusig®).

   B. Documentation of newly diagnosed chronic phase (CP) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML)

   C. Documented diagnosis of Myeloid/Lymphoid Neoplasms with Eosinophilia

      1. Presence of ABL1 tumor rearrangement.
      2. Documented trial and failure of, intolerance to, or contraindication to, imatinib.

II. Minimum age requirement: 18 years old.

III. Treatment must be prescribed by or in consultation with an oncologist or a hematologist..

IV. Request is for a medication with the appropriate FDA labeling, or its use is supported by current clinical practice guidelines.

V. Refer to plan document for the list of preferred products. If requested agent is not listed as a preferred product, must have a documented failure, intolerance, or contraindication to the preferred product(s).

EXCLUSION CRITERIA

- N/A

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- Doses are limited to 600 mg per day. The quantity is limited to a maximum of a 30-day supply per fill.

APPROVAL LENGTH

- **Authorization:** 1 year
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

APPENDIX

N/A

REFERENCES

1. Bosulif. Prescribing information. Pfizer Inc.; 2021. Accessed October 19, 2022. http://labeling.pfizer.com/ShowLabeling.aspx?id=884.
2. NCCN Clinical Practice Guidelines in Oncology. Chronic Myeloid Leukemia V.1.2023. Updated August 5, 2022. Accessed October 19, 2022. https://www.nccn.org/professionals/physician_gls/pdf/cml.pdf.
3. NCCN Clinical Practice Guidelines in Oncology. Myeloid/Lymphoid Neoplasms with Eosinophilia and tyrosine Kinase Fusion Genes V.2.2022. Updated October 18, 2022. Accessed October 19, 2022. https://www.nccn.org/professionals/physician_gls/pdf/mlne.pdf.