

## Chemotherapy Agents Prior Approval Policy

The purpose of this prior approval policy is to define specific criteria for coverage of chemotherapy agents to ensure that those agents are used for labeled conditions or for conditions that have supporting literature, and to ensure that National Comprehensive Cancer Network (NCCN) or American Society of Clinical Oncologist (ASCO) treatment guidelines are followed.

The following oncology agents will require prior approval and will be covered if the below-listed criteria are met.

Afinitor® (everolimus)	Tasigna® (nilotinib)
Etopophos® (etoposide)	Tykerb® (lapatinib)
Gleevec® (imatinib)	Xalkori® (crizotinib)
Revlimid® (lenalidomide)	Xeloda® (capecitabine)
Rituxan® (Rituximab)	Zelboraf® (vemurafenib)
Sprycel® (dasatinib)	Zolinza™ (vorinostat)

### CRITERIA

1. The prescription must be written by an oncologist or hematologist.
2. Dose must be within FDA approved limits OR based on NCCN/ASCO criteria.
3. Genetic or other required testing has been completed, if applicable.
4. The chemotherapy agent is a Food and Drug Administration (FDA) approved drug and is:
  - a. FDA approved for the cancer type being treated; or
  - b. Listed in one of the following compendia for treatment of cancer type; OR
    - American Hospital Formulary Service-Drug Information (AHFS-DI)
    - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
    - Thomson Micromedex DrugDex
    - Clinical Pharmacology
  - c. Recommended for the particular type of cancer in formal clinical studies, the results of which have been published in at least 2 peer reviewed professional medical journals published in the United States or Great Britain.
5. The chemotherapy agent is being used consistent with NCCN/ASCO guidelines in terms of place in therapy; if other agents are recommended prior to use of the requested agent, those other agents must have been used in the patient prior to approval of the requested agent.