

## Pre - PA Allowance

None

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## Prior-Approval Requirements

### Tasigna only

**Age** 1 year of age and older

### **Diagnoses**

Patient must have **ONE** of the following:

1. Chronic myeloid leukemia (CML)
  - a. Patient **MUST** have tried **ONE** of the preferred products (generic Sprycel: dasatinib or generic Gleevec: imatinib) unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)
2. Chronic myeloid leukemia (CML) with hematopoietic stem cell transplant (HSCT)
  - a. In combination with induction therapy
3. Ph+ Acute lymphoblastic leukemia (ALL)
4. Ph+ Acute lymphoblastic leukemia (ALL) post hematopoietic stem cell transplant (HSCT)
  - a. After achieving complete response to induction therapy

**AND ALL** of the following for **ALL** above indications:

1. Confirmed by molecular testing by the detection of the Ph chromosome or BCR-ABL gene prior to initiation of therapy
2. If the patient has had prior therapy with a TKI then **ONE** of the following requirements must be met:
  - a. Member experienced resistance to prior therapy with TKI
    - i. Results from mutational testing are negative for the T315I mutation
  - b. Member experienced toxicity or intolerance to prior therapy with a TKI
5. Gastrointestinal stromal tumor (GIST)

**TASIGNA, DANZITEN  
(nilotinib)**

- a. Disease progression after prior therapy with imatinib, sunitinib or regorafenib

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**Danziten only**

**Age** 18 years of age and older

**Diagnosis**

Patient must have the following:

1. Chronic myeloid leukemia (CML)
  - a. Confirmed by molecular testing by the detection of the Ph chromosome or BCR-ABL gene prior to initiation of therapy
  - b. Patient **MUST** have tried **ONE** of the preferred products (generic Sprycel: dasatinib or generic Gleevec: imatinib) unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

**AND ONE** of the following:

1. Newly diagnosed with chronic phase
2. Resistant to or intolerant to prior therapy that included imatinib

**Prior - Approval Limits**

**Quantity**

Tasigna	
Strength	Quantity
50 mg	504 capsules per 84 days <b>OR</b>
150 mg	336 capsules per 84 days <b>OR</b>
200 mg	336 capsules per 84 days

Danziten	
Strength	Quantity
71 mg	336 tablets per 84 days <b>OR</b>
95 mg	336 tablets per 84 days

**Duration** 12 months

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**BlueCross.  
BlueShield.**

Federal Employee Program.

## **TASIGNA, DANZITEN (nilotinib)**

### **Prior – Approval *Renewal* Requirements**

#### **Tasigna only**

**Age** 1 year of age and older

#### **Diagnoses**

Patient must have **ONE** of the following:

1. Chronic myeloid leukemia (CML)
  2. Chronic myeloid leukemia (CML) with hematopoietic stem cell transplant (HSCT)
  3. Ph+ Acute lymphoblastic leukemia (ALL)
  4. Ph+ Acute lymphoblastic leukemia (ALL) post hematopoietic stem cell transplant (HSCT)
  5. Gastrointestinal stromal tumor (GIST)
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#### **Danziten only**

**Age** 18 years of age and older

#### **Diagnosis**

Patient must have the following:

1. Chronic myeloid leukemia (CML)

### **Prior - Approval *Renewal* Limits**

Same as above