Reference number(s)
2173-A

Specialty Guideline Management Iclusig

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Iclusig	ponatinib

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.

FDA-Approved Indications[1]

- Adult patients with chronic phase (CP) chronic myeloid leukemia (CML) with resistance or intolerance to at least two prior kinase inhibitors
- Adult patients with accelerated phase (AP) or blast phase (BP) chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL) for whom no other kinase inhibitors are indicated
- Adult patients with newly diagnosed Ph+ ALL, in combination with chemotherapy.
- Adult patients with T315I-positive CML (chronic phase, accelerated phase, or blast phase) or T315I-positive Ph+ ALL

Limitation of Use

Iclusig is not indicated and is not recommended for the treatment of patients with newly diagnosed CP-CML.

Compendial Uses[2-4]

- Additional therapy for CML patients after hematopoietic stem cell transplant (HSCT)
- Ph+ B-cell acute lymphoblastic leukemia or lymphoblastic lymphoma (Ph+ B-ALL/LL)
- Maintenance therapy for Ph+ B-ALL/LL patients after hematopoietic stem cell transplant (HSCT)
- Myeloid/lymphoid neoplasms with eosinophilia and FGFR1 or ABL1 rearrangements in chronic phase or blast phase
- Gastrointestinal Stromal Tumors (GIST)

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

Documentation

The following information is necessary to initiate the prior authorization review:

- Prior to initiation of therapy 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
- For members requesting initiation of therapy with the requested medication for treatment of T315I-positive CML: results of BCR::ABL1 mutation testing for T315I mutation
- For members requesting initiation of therapy with the requested medication for treatment of myeloid and/or lymphoid neoplasms with eosinophilia: results of testing or analysis confirming FGFR1 or ABL1 rearrangement

Coverage Criteria

Chronic Myeloid Leukemia (CML)[1-3]

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 any of the following criteria are met:

- Member has T315I-positive CML
- Member has CML with no identifiable BCR::ABL1 mutations and resistance to primary therapy with asciminib, bosutinib, dasatinib, or nilotinib
- Member has chronic phase (CP) chronic myeloid leukemia (CML) with resistance or intolerance to at least two prior kinase inhibitors (e.g., asciminib, bosutinib, dasatinib, imatinib, nilotinib)
- Member has accelerated phase (AP) or blast phase (BP) CML and treatment with any other kinase inhibitors (e.g., asciminib, bosutinib, dasatinib, imatinib, nilotinib) is not indicated

Ph+ Acute Lymphoblastic Leukemia (ALL)/Lymphoblastic Lymphoma (LL)[1,2,4]

Authorization of 12 months may be granted for treatment of Ph+ ALL/LL that has been confirmed by detection of the Ph chromosome or BCR::ABL gene by cytogenetic and/or molecular testing.

Myeloid/Lymphoid Neoplasms with Eosinophilia[2]

Authorization of 12 months may be granted for treatment of myeloid and/or lymphoid neoplasms with eosinophilia and FGFR1 or ABL1 rearrangement in the chronic phase or blast phase.

Gastrointestinal Stromal Tumors (GIST)[2]

Authorization of 12 months may be granted for treatment of GIST as a single agent for residual, unresectable, tumor rupture or recurrent/metastatic disease after progression on at least four FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, and ripretinib).

Continuation of Therapy

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 are met:

- Authorization of 12 months may be granted when any of the following criteria is met:
    - 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
    - Member has received HSCT and there is no evidence of unacceptable toxicity or disease progression while on the current regimen
- Authorization of up to 7 months may be granted when the member has completed less than 6 months of therapy with the requested medication.

Ph+ ALL/LL

Authorization of 12 months may be granted for continued treatment of ALL/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:

- Member has Ph+ ALL/LL that has been confirmed by detection of Ph chromosome or BCR::ABL gene by cytogenetic and/ or molecular testing
- Member has received HSCT for ALL/LL

Myeloid/Lymphoid Neoplasms with Eosinophilia

Authorization of 12 months may be granted for continued treatment of myeloid/lymphoid neoplasms with eosinophilia when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

GIST

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

References

1. Iclusig [package insert]. Lexington, MA: Takeda Pharmaceuticals America, Inc.; September 2024.
2. The NCCN Drugs & Biologics Compendium® © 2025 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed April 15, 2025.
3. NCCN Clinical Practice Guidelines in Oncology® Chronic Myeloid Leukemia (Version 3.2025). © 2025 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed April 15, 2025.
4. NCCN Clinical Practice Guidelines in Oncology® Acute Lymphoblastic Leukemia (Version 3.2024). © 2025 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed April 15, 2025.