

CRITERIA FOR PRIOR AUTHORIZATION

Imbruvica (ibrutinib)

PROVIDER GROUP Pharmacy

MANUAL GUIDELINES The following drug requires prior authorization:
Imbruvica (ibrutinib)

CRITERIA FOR INITIAL APPROVAL (must meet all of the following):

- Patient must be clinically diagnosed with one of the following diagnoses:
 - Chronic lymphoid leukemia (CLL)
 - Small lymphocytic lymphoma (SLL)
 - Chronic lymphoid leukemia (CLL) with 17p chromosome deletion
 - Small lymphocytic lymphoma (SLL) with 17p chromosome deletion
 - Mantle cell lymphoma
 - Patient has received at least one prior therapy
 - Waldenström macroglobulinemia
- The medication is prescribed by or in consultation with an oncologist or hematologist

LENGTH OF APPROVAL: 6 months

CRITERIA FOR RENEWAL (must meet all of the following):

- Must meet initial criteria for renewal

RENEWAL LENGTH OF APPROVAL: 12 months

* Refer to most recent NCCN (National Comprehensive Cancer Network) Non-Hodgkin’s Lymphomas Guidelines for NCCN accepted regimens.

DRUG UTILIZATION REVIEW COMMITTEE CHAIR

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

DATE

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