Initial Approval Date: July 11, 2018
Revised Dates: January 20, 2021,
October 14, 2020, October 10, 2018

CRITERIA FOR PRIOR AUTHORIZATION

Oncology Agents

BILLING CODE TYPE For drug coverage and provider type information, see the KMAP Reference Codes webpage.

MANUAL GUIDELINES Prior authorization will be required for all current and future dose forms available. All medication-specific criteria will be reviewed according to the criteria below.

Brand Name	Generic Name
Adcetris	(brentuximab vedotin)
Afinitor	(everolimus)
Alecensa	(alectinib hcl)
Alunbrig	(brigatinib)
Arranon	(nelarabine)
Ayvakit	(avapritinib)
Balversa	(erdafitinib)
Bavencio	(avelumab)
Belrapzo	(bendamustine)
Bicnu	(carmustine)
Blincyto	(blinatumomab)
Bosulif	(bosutinib)
Braftovi	(encorafenib)
Brukinsa	(zanubrutinib)
Cabometyx	(cabozantinib)
Calquence	(acalabrutinib)
Cotellic	(cobimetinib)
Cyramza	(ramucirumab)
Darzalex	(daratumumab)
Darzalex Faspro	(daratumumab and hyaluronidase)
Empliciti	(elotuzumab)
Erbitux	(cetuximab)
Erivedge	(vismodegib)
Erleada	(apalutamide)
Erwinaze	(asparaginase erwinia chrysanthemi)
Farydak	(panobinostat)
Gavreto	(pralsetinib)
Gazyva	(obinutuzumab)
Gilotrif	(afatinib)
Gleevec	(imatinib mesylate)
Herceptin	(trastuzumab)
Herceptin Hylecta	(trastuzumab and hyaluronidase-oysk)
Herzuma	(trastuzumab)
Ibrance	(palbociclib)
Iclusig	(ponatinib hcl)
Idhifa	(enasidenib)
Imbruvica	(ibrutinib)
Imfinzi	(durvalumab)
Inlyta	(axitinib)
Ixempra	(ixabepilone)
Jakafi	(ruxolitinib phosphate)
Jevtana	(cabazitaxel)
Kadcyla	(ado-trastuzumab)
Kanjinti	(trastuzumab)
Keytruda	(pembrolizumab)
Kisqali	(ribociclib)
Kisqali Femara	(ribociclib-letrozole)
Kyprolis	(carfilzomib)
Lartruvo	(olaratumab)
Lenvima	(lenvatinib)
Lonsurf	(trifluridine-tipiracil)
Lorbrena	(lorlatinib)
Lynparza	(olaparib)
Matulane	(procarbazine)
Mekinist	(trametinib)
Mektovi	(binimetinib)
Mozobil	(plerixafor)
Nerlynx	(neratinib maleate)
Nexavar	(sorafenib tosylate)
Ninlaro	(ixazomib)
Ogivri	(trastuzumab)
Oncaspar	(pegaspargase)
Onivyde	(irinotecan liposome)
Ontruzant	(trastuzumab)
Opdivo	(nivolumab)
Padcev	(enfortumab vedotin)
Perjeta	(pertuzumab)
Phesgo	Pertuzumab, trastuzumab and hyaluronidase-zzxf)
Piqray	(alpelisib)
Polivy	(polatuzumab vedotin-piiq)
Pomalyst	(pomalidomide)

Brand Name	Generic Name	Brand Name	Generic Name
Provenge	(sipuleucel-T)	Trelstar	(triptorelin)
Revlimid	(lenalidomide)	Trodelvy	(sacituzumab govitecan)
Riabni	(rituximab)	Truxima	(rituximab)
Rituxan	(rituximab)	Tukysa	(tucatinib)
Rituxan Hycela	(rituximab and hyaluronidase human)	Tykerb	(lapatinib ditosylate)
		Valstar	(valrubicin)
Rozlytrek	(entrectinib)	Vectibix	(panitumumab)
Rubraca	(rucaparib)	Venclexta	(venetoclax)
Ruxience	(rituximab)	Verzenio	(abemaciclib)
Rydapt	(midostaurin)	Vitrakvi	(larotrectinib)
Sandostatin Lar	(octreotide)	Votrient	(pazopanib hcl)
Somatuline Depot	(lanreotide)	Xalkori	(crizotinib)
Sprycel	(dasatinib)	Xofigo	(radium Ra 223 dichloride)
Stivarga	(regorafenib)	Xospata	(gilteritinib fumarate)
Sutent	(sunitinib malate)	Xtandi	(enzalutamide)
Tabrecta	(capmatinib)	Yervoy	(ipilimumab)
Tafinlar	(dabrafenib)	Yonsa	(abiraterone acetate)
Tagrisso	(osimertinib)	Zejula	(niraparib)
Talzenna	(talazoparib tosylate)	Zelboraf	(vemurafenib)
Tarceva	(erlotinib)	Zirabev	(bevacizumab-bvzr)
Tasigna	(nilotinib hcl)	Zolinza	(vorinostat)
Tecentriq	(atezolizumab)	Zydelig	(idelalisib)
Tibsovo	(ivosidenib)	Zykadia	(ceritinib)
Trazimera	(trastuzumab)	Zytiga	(abiraterone acetate)

CRITERIA FOR INITIAL APPROVAL FOR ALL PRODUCTS (MUST MEET ALL OF THE FOLLOWING):

- Medication requested must be prescribed according to the FDA-approved indication, age, dose, and pre-requisite treatments located in the package insert.

CRITERIA FOR RENEWAL FOR ALL PRODUCTS:

- Prescriber must attest that the patient has experienced a positive clinical response from continuous treatment with the requested medication and is able to tolerate therapy.
- Patient must continue to meet the criteria required for initial approval.

LENGTH OF APPROVAL: 12 MONTHS

FOR DRUGS THAT HAVE A CURRENT PA REQUIREMENT, BUT NOT FOR THE NEWLY APPROVED INDICATIONS, FOR OTHER FDA-APPROVED INDICATIONS, AND FOR CHANGES TO AGE REQUIREMENTS NOT LISTED WITHIN THE PA CRITERIA:

- **THE PA REQUEST WILL BE REVIEWED BASED UPON THE FOLLOWING PACKAGE INSERT INFORMATION: INDICATION, AGE, DOSE, AND ANY PRE-REQUISITE TREATMENT REQUIREMENTS FOR THAT INDICATION.**

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR

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

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DATE