Reference number(s)
2172-A

Specialty Guideline Management imatinib products

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
Gleevec	imatinib mesylate
Imkeldi	imatinib

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

- Newly diagnosed adult and pediatric patients with Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase
- Patients with Ph+ CML in blast crisis, accelerated phase, or in chronic phase after failure of interferon-alpha therapy
- Adult patients with relapsed or refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL)
- Pediatric patients with newly diagnosed Ph+ ALL in combination with chemotherapy
- Adult patients with myelodysplastic/myeloproliferative diseases (MDS/MPD) associated with PDGFR (platelet-derived growth factor receptor) gene re-arrangements
- Adult patients with aggressive systemic mastocytosis without the D816V c-Kit mutation or with c-Kit mutational status unknown

- Adult patients with hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL) who have the FIP1L1-PDGFRα fusion kinase (mutational analysis or FISH demonstration of CHIC2 allele deletion) and for patients with HES and/or CEL who are FIP1L1-PDGFRα fusion kinase negative or unknown
- Adult patients with unresectable, recurrent and/or metastatic dermatofibrosarcoma protuberans (DFSP)
- Patients with Kit (CD117) positive unresectable and/or metastatic malignant gastrointestinal stromal tumors (GIST)
- Adjuvant treatment of adult patients following complete gross resection of Kit (CD117) positive GIST

Compendial Uses

- Primary treatment of advanced phase CML (accelerated phase or blast phase)
- 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 HSCT
- GIST
- Desmoid tumors
- Pigmented villonodular synovitis/tenosynovial giant cell tumor
- Recurrent chordoma
- Cutaneous melanoma
- Kaposi sarcoma that has progressed on or not responded to first-line systemic therapy
- Chronic myelomonocytic leukemia
- Chronic graft versus host disease
- Relapsed or refractory pediatric T-cell ALL/LL with ABL-class translocation
- Myeloid/lymphoid neoplasms with eosinophilia and the ABL1, FIP1L1::PDGFRA, or PDGFRB rearrangement in chronic phase or blast phase
- Aggressive Systemic Mastocytosis (ASM)
- Dermatofibrosarcoma Protuberans (DFSP)

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

Documentation

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

- 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 treatment of T-cell ALL/LL: results of cytogenetic and/or molecular testing confirming ABL-class translocation
- For treatment of MDS/MPD and CMML: results of molecular testing or analysis confirming PDGFR gene rearrangement

- For the treatment of ASM: results of molecular testing or analysis for D816V c-KIT mutation and FIP1L1::PDGFRA fusion gene (where applicable)
- For treatment of melanoma: results of molecular testing or analysis confirming c-KIT activating mutation
- For treatment of myeloid and/or lymphoid neoplasms with eosinophilia: results of testing or analysis confirming ABL1, FIP1L1::PDGFRA, or PDGFRB rearrangement

Coverage Criteria

Chronic Myeloid Leukemia (CML)

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 the member did not fail (other than due to intolerance) prior therapy with a TKI (e.g., dasatinib, nilotinib, bosutinib, ponatinib).

Acute Lymphoblastic Leukemia (ALL)/Lymphoblastic Lymphoma (LL)

Authorization of 12 months may be granted for treatment of ALL/LL when any of the following criteria is met:

- Member has Ph+ ALL/LL that has been confirmed by detection of the Ph chromosome or BCR::ABL gene by cytogenetic and/or molecular testing
- Member has T-cell ALL/LL with ABL-class translocation that has been confirmed by cytogenetic and/or molecular testing and the disease is relapsed or refractory
- Member has received HSCT for Ph+ ALL/LL

Gastrointestinal Stromal Tumor (GIST), Desmoid Tumors, Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor (PVNS/TGCT), Hypereosinophilic Syndrome/Chronic Eosinophilic Leukemia (HES/CEL), Dermatofibrosarcoma Protuberans (DFSP), Chordoma

Authorization of 12 months may be granted for treatment of GIST, desmoid tumors, PVNS/TGCT, HES/CEL, DFSP, or recurrent chordoma.

Myelodysplastic Syndromes/Myeloproliferative Diseases (MDS/MPD) and Chronic Myelomonocytic Leukemia (CMML)

Authorization of 12 months may be granted for treatment of MDS/MPD or CMML when the member's disease is associated with PDGFR (platelet-derived growth factor receptor) gene rearrangements.

Aggressive Systemic Mastocytosis (ASM)

Authorization of 12 months may be granted for treatment of ASM, as a single agent, when any of the following criteria is met:

- D816V c-KIT mutation is negative
- D816V c-KIT mutation status is unknown
- Well-differentiated systemic mastocytosis (WDSM)
- Eosinophilia is present with FIP1L1::PDGFRA fusion gene

Cutaneous Melanoma

Authorization of 12 months may be granted for treatment of cutaneous melanoma when all of the following criteria are met:

- The disease is metastatic or unresectable
- The tumor has c-KIT activating mutations
- The requested medication will be used as subsequent therapy
- Member has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy
- The requested medication will be used as a single agent

Kaposi Sarcoma

Authorization of 12 months may be granted for treatment of Kaposi sarcoma when the requested medication is used as subsequent therapy as a single agent or in combination with antiretroviral therapy.

Chronic Graft-Versus-Host Disease (cGVHD)

Authorization of 12 months may be granted for treatment of cGVHD when the requested medication is used as subsequent therapy in combination with systemic corticosteroids.

Myeloid/Lymphoid Neoplasms with Eosinophilia

Authorization of 12 months may be granted for treatment of myeloid and/or lymphoid neoplasms with eosinophilia and ABL1, FIP1L1::PDGFRA, or PDGFRB rearrangement in the chronic phase or blast phase.

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 is 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 disease progression or unacceptable toxicity 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.

Acute Lymphoblastic Leukemia or Lymphoblastic Lymphoma (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 any 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 T-cell ALL/LL with ABL-class translocation that has been confirmed by cytogenetic and/or molecular testing.
- Member has received HSCT for ALL/LL

Desmoid Tumors, PVNS/TGCT, HES/CEL, DFSP, Chordoma, MDS/MPD, CMML, ASM, Cutaneous Melanoma, Kaposi sarcoma, cGVHD, or Myeloid/Lymphoid Neoplasms with Eosinophilia

Authorization of 12 months may be granted for continued treatment of desmoid tumors, PVNS/TGCT, HES/CEL, DFSP, chordoma, MDS/MPD, CMML, ASM, cutaneous melanoma, Kaposi sarcoma, cGVHD, or 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 the member is receiving clinical benefit and there is no evidence of unacceptable toxicity while on the current regimen.

References

1. Gleevec [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2024.
2. imatinib [package insert]. Cranbury, NJ: Sun Pharmaceuticals Industries, Inc.; September 2022.
3. Imkeldi [package insert]. Cambridge, MA: Shorla Oncology Inc.; December 2024.
4. The NCCN Drugs & Biologics Compendium® © 2024 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed April 9, 2024.
5. NCCN Clinical Practice Guidelines in Oncology® Acute Lymphoblastic Leukemia (Version 4.2023). © 2024 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed April 9, 2024.
6. NCCN Clinical Practice Guidelines in Oncology® Pediatric Acute Lymphoblastic Leukemia (ALL) (Version 4.2024). © 2024 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed April 9, 2024.
7. NCCN Clinical Practice Guidelines in Oncology® Myelodysplastic Syndromes (Version 1.2024). © 2024 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed April 9, 2024.