

Policy and Procedure	
PHARMACY PRIOR AUTHORIZATION POLICY AND CRITERIA ORPTCONC103.0226	ANTINEOPLASTICS AGENTS ANTI-CANCER MEDICATIONS – SELF-ADMINISTERED See Appendix A for medications covered by policy
Effective Date: 4/1/2026	Review/Revised Date: 04/16, 12/16, 05/17, 07/17, 10/17, 01/17, 05/18, 08/18, 01/19, 04/19, 10/19, 01/20, 07/20, 08/20, 10/20, 12/20, 01/21, 03/21, 05/21, 07/21, 12/21, 01/22, 04/22, 01/23, 04/23, 07/23, 12/23, 12/23, 04/24, 08/24, 10/24, 12/24, 01/25, 02/25, 03/25, 06/25, 07/25, 08/25, 10/25, 01/26 (JEF/JH/MTW)
Original Effective Date: 08/16	P&T Committee Meeting Date: 06/16, 02/17, 06/17, 8/17, 10/17, 12/17, 02/18, 06/18, 10/18, 02/19, 04/19, 08/19, 10/19, 02/20, 04/20, 06/20, 08/20, 10/20, 12/20, 04/21, 06/21, 08/21, 12/21, 02/22, 06/22, 02/23, 04/23, 06/23, 08/23, 12/23, 02/24, 04/24, 08/24, 10/24, 12/24, 02/25, 04/25, 06/25, 08/25, 10/25, 02/26
Approved by: Oregon Region Pharmacy and Therapeutics Committee	

SCOPE:

Providence Health Plan and Providence Health Assurance as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

Commercial
Medicaid

POLICY CRITERIA:

COVERED USES:

All medically accepted indications not otherwise excluded from the benefit.

For off-label use criteria, please see the Chemotherapy Treatment Utilization Criteria, Coverage for Non-FDA Approved Indications ORPTCOPS105.

REQUIRED MEDICAL INFORMATION:

For initiation of therapy, all the following criteria must be met:

1. Use must be for an FDA approved indication or indication supported by National Comprehensive Cancer Network guidelines with recommendation 2A or higher
2. Dosing and frequency are within FDA-labeled guidelines or supported by NCCN guidelines
3. The following drug-specific criteria must be met for **both Commercial and Medicaid members:**
 - a. For requests for abiraterone (Zytiga) or Yonsa (micronized abiraterone acetate): only generic abiraterone 250 mg tablets will be covered when criterion 1 is met, unless documentation of sufficient medical rationale for using the requested formulation over generic abiraterone 250 mg tablets is provided.
 - b. For requests for pazopanib 400 mg tablets: only generic pazopanib 200 mg tablets will be covered when criterion 1 is met, unless documentation

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCONC103**

**ANTINEOPLASTICS AGENTS
ANTI-CANCER MEDICATIONS –
SELF-ADMINISTERED**

See [Appendix A](#) for medications covered by policy

- of sufficient medical rationale for using this formulation over generic pazopanib 200 mg tablets is provided.
- c. For requests for everolimus tablet for suspension, one of the following criteria (i or ii) must be met:
 - i. Use for adjunctive treatment of tuberous sclerosis complex-associated partial-seizures, or
 - ii. Documentation of a physical or medical condition that either makes swallowing tablets a choking hazard, or requires solution for administration (such as young age, dysphagia, feeding tube)
 - d. For imatinib mesylate solution (Imkeldi): Documentation of a physical or medical condition that either makes swallowing tablets a choking hazard, or requires solution for administration (such as young age, dysphagia, feeding tube)
 - e. For lazertinib (Lazcluze): Documented contraindication to Tagrisso or prescriber has provided clinical rationale in support of Lazcluze over Tagrisso with or without chemotherapy
 - f. For Hernexeos (zongertinib) for patients weighing 90 kilograms or greater: Documented contraindication to Hyrnuo (sevabertinib) or prescriber has provided clinical rationale in support of Hernexeos (zongertinib) over Hyrnuo (sevabertinib)
4. The following drug-specific criteria must be met for **Commercial members only**:
- a. For palbociclib (Ibrance) for advanced or metastatic breast cancer: Documented trial, failure, intolerance, or contraindication to ribociclib (Kisqali) or abemaciclib (Verzenio)
Note: Criteria waived if using in combination with inavolisib (Itovebi) and fulvestrant for the treatment of adults with endocrine-resistant, PIK3CA-mutated, hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, locally advanced or metastatic breast cancer
 - b. For talazoparib (Talzenna) for recurrent or metastatic breast cancer: Documented trial, failure, intolerance, or contraindication to olaparib (Lynparza)
 - c. For nilotinib (Tasigna), nilotinib (Danziten), nilotinib d-tartrate, bosutinib (Bosulif), or dasatinib (Sprycel): Documented trial, failure, intolerance, or contraindication to imatinib unless one of the following:
 - i. NCCN does not support the use of imatinib for the requested indication, or
 - ii. The prescriber has provided information in support over the use of Tasigna or Danziten or nilotinib d-tartrate or dasatinib (Sprycel) over imatinib for the requested indication (such as chronic myeloid leukemia in accelerated phase or patients with ETV6::ABL1 gene fusion)

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCONC103**

**ANTINEOPLASTICS AGENTS
ANTI-CANCER MEDICATIONS –
SELF-ADMINISTERED**

See [Appendix A](#) for medications covered by policy

For patients established on therapy, the following must be met:

1. Documentation of adequate response to the medication must be provided, such as disease stability or positive response to therapy.
2. Treatment regimen has been previously approved for coverage or use is supported by National Comprehensive Cancer Network guidelines with recommendation 2A or higher.

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS:

Age must be appropriate based on medically accepted indications.

PRESCRIBER RESTRICTIONS:

Must be prescribed by, or in consultation with, an oncologist unless otherwise specified below:

For avapritinib (Ayvakit): May also be prescribed by an allergist or immunologist
For pacritinib (Vonjo): May also be prescribed by a hematologist
For abiraterone acetate (Zytiga): May also be prescribed by a urologist

COVERAGE DURATION:

Initial authorization will be approved for one year.
Reauthorization will be approved for one year.

QUANTITY LIMIT:

See [Appendix A](#) for medication-specific quantity limit.

For off-label use criteria please see the Chemotherapy Treatment Utilization Criteria; Coverage for Non-FDA Approved Indications ORPTCOPS105.

Requests for indications that were approved by the FDA within the previous six (6) months may not have been reviewed by the health plan for safety and effectiveness and inclusion on this policy document. These requests will be reviewed using the New Drug and or Indication Awaiting P&T Review; Prior Authorization Request ORPTCOPS047.

Requests for a non-FDA approved (off-label) indication requires the proposed indication be listed in either the American Hospital Formulary System (AHFS), Drugdex, or the National Comprehensive Cancer Network (NCCN) and is considered subject to evaluation of the prescriber's medical rationale, formulary alternatives, the available published evidence-based research and whether the proposed use is determined to be experimental/investigational.

Coverage for Medicaid is limited to a condition that has been designated a covered line item number by the Oregon Health Services Commission listed on the Prioritized List of Health Care Services.

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCONC103**

**ANTINEOPLASTICS AGENTS
ANTI-CANCER MEDICATIONS –
SELF-ADMINISTERED**

See [Appendix A](#) for medications covered by policy

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

INTRODUCTION:

Medications used in the treatment of cancer pose a risk for serious side effects; their efficacy is indeterminate outside of indications for which clinical trial evidence available. Additionally, many medications to treat cancer are high in cost. Prior authorization review of oncology medication allows for an assessment of safety and efficacy data for medication(s) requested for a member.

FDA APPROVED INDICATIONS:

Refer to Micromedex for FDA approved indications of individual medications.

POSITION STATEMENT:

Use of oncology medications outside of the Food and Drug Administration (FDA) approved indication may be supported by clinical trial data. National Comprehensive Cancer Network (NCCN) provides evidence-based Clinical Practice Guidelines in Oncology (NCCN Guidelines) steered by consensus from a panel of subspecialists. FDA labeled and non-FDA approved indications are included. Guidelines are reviewed annually and updated as new data becomes available. The NCCN Drugs & Biologics Compendium (NCCN Compendium), based directly on NCCN Guidelines, lists indications for each individual medication for which there is a recommendation for use, with the category of recommendation (see description below) included. The NCCN Guidelines and NCCN Compendium are intended to aid clinicians and payers in decisions regarding treatment of cancer.

National Comprehensive Cancer Network (NCCN) Categories for Recommendations

	Description of Evidence and Consensus
Category 1	Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2A	Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2B	Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
Category 3	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCONC103**

**ANTINEOPLASTICS AGENTS
ANTI-CANCER MEDICATIONS –
SELF-ADMINISTERED**

See [Appendix A](#) for medications covered by policy

The NCCN Compendium is one reference utilized in the coverage determination process, based on the operational policy: Chemotherapy Treatment Utilization Criteria; Coverage for Non-FDA Approved Indications ORPTCOPS105.

Utilization of oncology medications are currently managed through prior authorization and step therapy when appropriate. The Companies have chosen to favor the use of generic products or preferred agents, where noted in the clinical policy, to provide quality clinical care to our members in the most cost-effective manner.

Lazertinib mesylate (Lazcluze):

Lazertinib (Lazcluze), is a third-generation kinase inhibitor of epidermal growth factor receptor (EGFR) for first-line treatment in combination with intravenous amivantamab (Rybrevant) of non–small cell lung cancer (NSCLC), locally advanced or metastatic, with EGFR exon 19 deletion or exon 21 L858R substitution mutation. Other first line therapies include osimertinib (Tagrisso) [as single agent] and osimertinib in combination with pemetrexed and platinum-based chemotherapy (cisplatin or carboplatin). Both osimertinib + amivantamab and osimertinib + pemetrexed + platinum-based chemotherapy combinations have improved progression free survival over osimertinib alone. There is no direct evidence of efficacy superiority, including overall survival, between the two different therapy combinations. NCCN non-small cell lung cancer guidelines recommend either of these combinations as *other recommended first-line therapy*. Lazertinib + amivantamab is currently only recommended as first-line or for continuation of therapy following disease progression. It does not have evidence for use as second line or subsequent therapy.

REFERENCE/RESOURCES:

1. About the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines). <https://www.nccn.org/home/about>. Accessed January 9, 2024.
2. NCCN Categories of Evidence and Consensus. http://www.nccn.org/professionals/physician_gls/categories_of_consensus.as p. Accessed January 9, 2024.
3. Micromedex: DRUGDEX[®] System [Internet database]. Greenwood Village, CO: Thomson Reuters (Healthcare) Inc.; Updated periodically.

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCONC103**

**ANTINEOPLASTICS AGENTS
ANTI-CANCER MEDICATIONS –
SELF-ADMINISTERED**

See [Appendix A](#) for medications covered by policy

APPENDIX A. Anti-cancer medications

Brand Name	Generic Name/Dosage form	Quantity Limit
Actimmune	interferon gamma-1B recomb	
Afinitor	everolimus tablet	<ul style="list-style-type: none"> • Tablets (2.5 mg, 5 mg, 7.5 mg, 10 mg): One tablet per day
Afinitor Disperz	everolimus tablet for oral suspension	<ul style="list-style-type: none"> • 2.5 mg: Two tablets per day • 3 mg: Three tablets per day • 5 mg: Two tablets per day
Akeega	niraparib tosylate/abiraterone acetate tablet	<ul style="list-style-type: none"> • Tablets (50-500 mg, 100-500 mg): Two tablets per day
Alecensa	alectinib capsule	<ul style="list-style-type: none"> • 150 mg: Eight capsules per day
N/A	melphalan tablet	
Alunbrig	brigatinib tablet	<ul style="list-style-type: none"> • 30 mg: Four tablets per day • 90 mg: One tablet per day • 180 mg: One tablet per day • 90mg-180mg dose pack: One dose pack per day
Augtyro	repotrectinib capsule	<ul style="list-style-type: none"> • 40mg: Eight capsules per day • 160mg: Two capsules per day
Avmapki-Fakzinja	Autometinib/defactinib	<ul style="list-style-type: none"> • 0.8-200 mg combo package: One package per 28 days
Ayvakit	avapritinib tablet/ pack	<ul style="list-style-type: none"> • Tablets (25 mg, 50 mg, 100 mg, 200 mg, 300 mg): One tablet per day
Balversa	erdafitinib tablet	<ul style="list-style-type: none"> • 3 mg: Three tablets per day • 4 mg: Two tablets per day • 5 mg: One tablet per day
Besremi	ropeginterferon alfa-2b syringe	<ul style="list-style-type: none"> • 500 mcg/ml: Two syringes per 28 days
Bosulif	bosutinib tablet/capsule	<ul style="list-style-type: none"> • 50 mg capsule: One capsule per day • 100 mg capsule: Six capsules per day • 100 mg tablet: Four tablets per day • 400 mg tablet: One tablet per day • 500 mg tablet: One tablet per day
Braftovi	encorafenib capsule	<ul style="list-style-type: none"> • 75 mg: Six capsules per day
Brukinsa	zanubrutinib capsule	<ul style="list-style-type: none"> • 80 mg: Four capsules per day
Cabometyx	cabozantinib tablet	<ul style="list-style-type: none"> • Tablets (20 mg, 40 mg, 60 mg): One tablet per day
Calquence	acalabrutinib tablet	<ul style="list-style-type: none"> • 100 mg: Two tablets per day

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCONC103**

**ANTINEOPLASTICS AGENTS
ANTI-CANCER MEDICATIONS –
SELF-ADMINISTERED**

See [Appendix A](#) for medications covered by policy

Brand Name	Generic Name/Dosage form	Quantity Limit
Caprelsa	vandetanib tablet	<ul style="list-style-type: none"> • 100 mg: Two tablets per day • 300 mg: One tablet per day
Cometriq	cabozantinib capsule	<ul style="list-style-type: none"> • 60 mg: Three capsules per day • 100 mg: Two capsules per day • 140 mg: Four capsules per day
Copiktra	duvelisib capsule	<ul style="list-style-type: none"> • Capsules (15 mg, 25 mg): Two capsules per day
Cotellic	cobimetinib tablet	<ul style="list-style-type: none"> • 20 mg: 63 tablets per 28 days
Danziten	nilotinib tablet	<ul style="list-style-type: none"> • Tablets (25 mg, 71 mg): Four tablets per day
N/A, generic only	Nilotinib d-tartrate	<ul style="list-style-type: none"> • 150 mg: four capsules per day • 200 mg: four capsules per day
Daurismo	glasdegib tablet	<ul style="list-style-type: none"> • 25 mg: Two tablets per day • 100 mg: One tablet per day
Ensacove	ensartinib capsule	<ul style="list-style-type: none"> • 25 mg: one capsule per day • 100 mg: 2 capsules per day
Erivedge	vismodegib capsule	<ul style="list-style-type: none"> • 150 mg: One tablet per day
Erleada	apalutamide tablet	<ul style="list-style-type: none"> • 60 mg: Four tablets per day • 240 mg: One tablet per day
Farydak	panobinostat capsule	<ul style="list-style-type: none"> • Capsules (10 mg, 15 mg, 20 mg): Six tablets per 21 days
Fotivda	tivozanib capsule	<ul style="list-style-type: none"> • Capsules (0.89 mg, 1.34 mg): 21 capsules per 28 days
Fruzaqla	fruquintinib capsule	<ul style="list-style-type: none"> • 1 mg: 105 capsules per 28 days • 5 mg: 21 capsules per 28 days
Gavreto	pralsetinib capsule	<ul style="list-style-type: none"> • 100 mg: Four capsules per day
Gilotrif	afatinib tablet	<ul style="list-style-type: none"> • Tablets (20 mg, 30 mg, 40 mg): One tablet per day
Gleevec*	imatinib mesylate tablet	<ul style="list-style-type: none"> • 100 mg: Three tablets per day • 400 mg: Two tablets per day
Gomekli	mirdametinib capsule/tablet, dispersible	<ul style="list-style-type: none"> • 1 mg capsule: Eight capsules per day • 1 mg tablet suspension: Eight tablets per day • 2 mg capsule: Four capsules per day
Hernexeos	Zongertinib tablet	<ul style="list-style-type: none"> • 60 mg: Three tablets per day
Hyrnuo	Sevabertinib tablet	<ul style="list-style-type: none"> • Four tablets per day
Ibrance	palbociclib tablet/capsules	<ul style="list-style-type: none"> • Tablets (75 mg, 100 mg, 125 mg): 21 tablets per 28 days

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCONC103**

**ANTINEOPLASTICS AGENTS
ANTI-CANCER MEDICATIONS –
SELF-ADMINISTERED**

See [Appendix A](#) for medications covered by policy

Brand Name	Generic Name/Dosage form	Quantity Limit
		<ul style="list-style-type: none"> • Capsules (75 mg, 100 mg, 125 mg) capsule: 21 capsules per 28 days
Ibtrozi	taletrectinib adipate capsule	<ul style="list-style-type: none"> • 200 mg: Three capsules per day
Iclusig	ponatinib tablet	<ul style="list-style-type: none"> • Tablets (10 mg, 15 mg, 30 mg, 45 mg): One tablet per day
Idhifa	enasidenib tablet	<ul style="list-style-type: none"> • Tablets (50 mg, 100 mg): One tablet per day
Imbruvica	ibrutinib tablet/capsule/oral suspension	<ul style="list-style-type: none"> • Tablets (140 mg, 280 mg, 420 mg): One tablet per day • 140 mg capsule: Two capsules per day • 70 mg capsule: Three capsules per day • 70 mg/mL suspension: Six mL per day
Imkeldi	imatinib mesylate solution	<ul style="list-style-type: none"> • 80 mg/mL solution: 10 mL per day
Inlyta	axitinib tablet	<ul style="list-style-type: none"> • 1 mg: Six tablets per day • 5 mg: Four tablets per day
Inqovi	decitabine/cedazuridine tablet	<ul style="list-style-type: none"> • 35-100 mg tablet: Five tablets per 28 days
Inrebic	fedratinib capsule	<ul style="list-style-type: none"> • 100 mg: Four capsules per day
Iressa	gefitinib tablet	<ul style="list-style-type: none"> • 250 mg: One tablet per day
Itovebi	inavolisib tablet	<ul style="list-style-type: none"> • 3 mg: Two tablets per day • 9 mg: One tablet per day
Iwilfin	eflornithine tablet	<ul style="list-style-type: none"> • 192 mg: Eight tablets per day
Jakafi	ruxolitinib tablet	<ul style="list-style-type: none"> • Tablets (5 mg, 10 mg, 15 mg, 20 mg, 25 mg): Two tablets per day
Jaypirca	pirtobrutinib tablet	<ul style="list-style-type: none"> • 50 mg: One tablet per day • 100 mg: Three tablets per day
Kisqali	ribociclib tablet	<ul style="list-style-type: none"> • 200 mg: 21 tablets per 28 days • 400 mg: 42 tablets per 28 days • 600 mg: 63 tablets per 28 days
Kisqali Femara	Ribociclib succinate/letrozole	<ul style="list-style-type: none"> • 200-2.5 mg: 49 tablets per 28 days • 400-2.5 mg: 70 tablets per 28 days • 600-2.5 mg: 91 tablets per 28 days
Komzifti	Ziftomenib capsule	<ul style="list-style-type: none"> • 200 mg: 3 capsules per day
Koselugo	selumetinib capsule	<ul style="list-style-type: none"> • 10 mg: Eight capsules per day • 25 mg: Four capsules per day
Krazati	adagrasib tablet	<ul style="list-style-type: none"> • 200 mg: Six tablets per day
Lazcluze	lazertinib mesylate tablet	<ul style="list-style-type: none"> • 80 mg: 2 tablets per day • 240 mg: 1 tablet per day

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCONC103**

**ANTINEOPLASTICS AGENTS
ANTI-CANCER MEDICATIONS –
SELF-ADMINISTERED**

See [Appendix A](#) for medications covered by policy

Brand Name	Generic Name/Dosage form	Quantity Limit
Lenvima	lenvatinib capsule/capsule dose packs	<ul style="list-style-type: none"> • 4 mg: One capsule per day • 8 mg/day dose pack: Two capsules per day • 10 mg/day dose pack: One capsule per day • 12 mg/day dose pack: Three capsules per day • 14 mg/day dose pack: Two capsules per day • 18 mg/day dose pack: Three capsules per day • 20 mg/day dose pack: Two capsules per day • 24 mg/day dose pack: Three capsules per day
Lonsurf	trifluridine - tipracil and tablet	<ul style="list-style-type: none"> • 15-6.14mg: Ten tablets per day • 20-8.19mg: Eight tablets per day
Lorbrena	lorlatinib tablet	<ul style="list-style-type: none"> • 25 mg: Three tablets per day • 100 mg: One tablet per day
Lumakras	sotorasib tablet	<ul style="list-style-type: none"> • 120 mg: Eight tablets per day • 240 mg: Four tablets per day • 320 mg: Three tablets per day
Lynparza	olaparib tablet	<ul style="list-style-type: none"> • Tablets (100 mg, 150 mg): Four tablets per day
Lysodren	mitotane tablet	
Lytgobi	futibatinib tablet dose packs	<ul style="list-style-type: none"> • 12 mg/day dose pack: Three tablets per day • 16 mg/day dose pack: Four tablets per day • 20 mg/day dose pack: Five tablets per day
Mekinist	trametinib tablet/solution	<ul style="list-style-type: none"> • 0.05 mg/ml solution: 40 mls per day • 0.5 mg: Three tablets per day • 2 mg: One tablet per day
Mektovi	binimetinib tablet	<ul style="list-style-type: none"> • 15 mg: Six tablets per day
Modeyso	dordaviprone hcl capsule	<ul style="list-style-type: none"> • 125 mg: 20 capsules per 28 days
Nerlynx	neratinib maleate tablet	<ul style="list-style-type: none"> • 40 mg: Six tablets per day
Nexavar	sorafenib tablet	<ul style="list-style-type: none"> • 200 mg: Four tablets per day

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCONC103**

**ANTINEOPLASTICS AGENTS
ANTI-CANCER MEDICATIONS –
SELF-ADMINISTERED**

See [Appendix A](#) for medications covered by policy

Brand Name	Generic Name/Dosage form	Quantity Limit
Ninlaro	ixazomib capsule	<ul style="list-style-type: none"> • Capsules (2.3 mg, 3 mg, 4 mg): Three capsules per 28 days
Nubeqa	darolutamide tablet	<ul style="list-style-type: none"> • 300 mg: Four tablets per day
Odomzo	sonidegib capsule	<ul style="list-style-type: none"> • 200 mg: One capsule per day
Ogsiveo	nirogacestat tablet	<ul style="list-style-type: none"> • 50 mg: Six tablets per day • 100 mg: Two tablets per day • 150 mg: Two tablets per day
Ojemda	tovorafenib tablet and suspension	<ul style="list-style-type: none"> • 25 mg/mL suspension: 96 mL/28 days • 400 mg/week pack: 16 tablets per 28 days (1 box) • 500 mg/week pack: 20 tablets per 28 days (1 box) • 600 mg/week pack: 24 tablets per 28 days (1 box)
Ojjaara	momelotinib tablet	<ul style="list-style-type: none"> • Tablets (100 mg, 150 mg, 200 mg): One tablet per day
Onureg	azacitidine tablet	<ul style="list-style-type: none"> • Tablets (200mg, 300 mg): 14 tablets per 28 days
Orgovyx	relugolix tablet	<ul style="list-style-type: none"> • 120 mg: 32 tablets per 30 days
Orserdu	elacestrant tablet	<ul style="list-style-type: none"> • 86 mg: Three tablets per day • 345 mg: One tablet per day
Pemazyre	pemigatinib tablet	<ul style="list-style-type: none"> • Tablets (4.5 mg, 9 mg, 13.5 mg): 14 tablets per 21 days
Piqray	alpelisib tablet	<ul style="list-style-type: none"> • 200 mg/day pack: One tablet per day • 250 mg/day pack: Two tablets per day • 300 mg/day pack: Two tablets per day
Pomalyst	pomalidomide capsule	<ul style="list-style-type: none"> • Capsule (1 mg, 2 mg, 3 mg, 4 mg): 21 capsules per 28 days
Qinlock	ipretinib tablet	<ul style="list-style-type: none"> • 50 mg: Three tablets per day
Retevmo	selpercatinib tablet	<ul style="list-style-type: none"> • 40 mg: Six per day • 80 mg: Four per day • 120 mg: Two per day • 160 mg: Two per day
Revlimid	lenalidomide capsule	<ul style="list-style-type: none"> • 2.5 mg/5 mg/10 mg: One capsule per day • 15 mg/20 mg/25 mg: 21 capsules per 28 days
Revuforj	revumenib tablet	<ul style="list-style-type: none"> • 25 mg: Twelve tablets per day • 110 mg: Four tablets per day

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCONC103**

**ANTINEOPLASTICS AGENTS
ANTI-CANCER MEDICATIONS –
SELF-ADMINISTERED**

See [Appendix A](#) for medications covered by policy

Brand Name	Generic Name/Dosage form	Quantity Limit
		<ul style="list-style-type: none"> 160 mg: Two tablets per day
Rezlidhia	olutasidenib capsule	<ul style="list-style-type: none"> 150 mg: Two capsules per day
Romvimza	vimseltinib capsule	<ul style="list-style-type: none"> 14 mg: Eight capsules per 28 days 20 mg: Eight capsules per 28 days 30 mg: Eight capsules per 28 days
Rozlytrek	entrectinib capsule/pellet pack	<ul style="list-style-type: none"> 100 mg: 5 capsules per day 200 mg: 3 capsules per day 50 mg pellet pack: 12 pellets per day
Rubraca	rucaparib tablet	<ul style="list-style-type: none"> Tablet (200mg, 250 mg, 300 mg): Four tablets per day
Rydapt	midostaurin capsule	<ul style="list-style-type: none"> 25 mg: Eight capsules per day
Scemblix	asciminib tablet	<ul style="list-style-type: none"> 20 mg/40 mg: Two tablets per day 100 mg: 4 tablets per day
Sprycel	dasatinib tablet	<ul style="list-style-type: none"> 20 mg: Three tablets per day 50 mg, 70 mg, 80 mg, 100 mg, 140 mg: One tablet per day
Stivarga	regorafenib oral tablet	<ul style="list-style-type: none"> 40 mg: 84 tablets per 28 days
Sutent	sunitinib malate capsule	<ul style="list-style-type: none"> 25 mg/37.5 mg/50 mg: One capsule per day 12.5 mg: Three capsules per day
Tabrecta	capmatinib tablet	<ul style="list-style-type: none"> Tablet (150 mg, 200 mg): Four tablets per day
Tafinlar	dabrafenib capsule/tablet for suspension	<ul style="list-style-type: none"> Capsule (50 mg, 75 mg): Four capsules per day 10 mg: 30 tablets for suspension per 1 day
Tagrisso	osimertinib mesylate tablet	<ul style="list-style-type: none"> Tablet (40 mg, 80 mg): One tablet per day
Talzenna	talazoparib oral capsule	<ul style="list-style-type: none"> 0.35 mg, 0.5 mg, 0.75 mg, 0.1 mg, 1 mg capsule: One capsule per day 0.25 mg: Three capsules per day
Tarceva	erlotinib tablet	<ul style="list-style-type: none"> 100 mg, 150 mg tablet: One tablet per day 25 mg: Three tablets per day
Targretin	bexarotene capsules and gel	<ul style="list-style-type: none"> 1% gel: 60 grams per 30 days 75 mg: 10 capsules per day
Tasigna	nilotinib capsule	<ul style="list-style-type: none"> Capsules (50 mg, 150 mg, 200 mg): Four capsules per day

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCONC103**

**ANTINEOPLASTICS AGENTS
ANTI-CANCER MEDICATIONS –
SELF-ADMINISTERED**

See [Appendix A](#) for medications covered by policy

Brand Name	Generic Name/Dosage form	Quantity Limit
Tazverik	tazemetostat hydrobromide tablet	<ul style="list-style-type: none"> 200 mg: Eight tablets per day
Temodar	temozolomide capsule	
Tepmetko	tepotinib tablet	<ul style="list-style-type: none"> 225 mg: Two tablets per day
Tibsovo	ivosidenib tablet	<ul style="list-style-type: none"> 250 mg: Two tablets per day
Truqap	capivasertib tablet	<ul style="list-style-type: none"> Tablet (160 mg, 200 mg): 64 tablets per 28 days
Tukysa	tucatinib tablet	<ul style="list-style-type: none"> 50 mg: Ten tablets per day 150 mg: Four tablets per day
Turalio	pexidartinib capsule	<ul style="list-style-type: none"> 125 mg: Four capsules per day
Tykerb	lapatinib tablet	<ul style="list-style-type: none"> 250 mg: Six tablets per day
Vanflyta	quizartinib dihydrochloride tablet	<ul style="list-style-type: none"> Tablet (17.7 mg, 26.5 mg): Two tablets per day
Venclexta	venetoclax tablet/tablet dose packs	<ul style="list-style-type: none"> 10 mg: Two tablets per day 50 mg: One tablet per day 100 mg: Six tablets per day 10-50-100 tablet dose pack: 42 tablets per 28 days
Verzenio	abemaciclib	<ul style="list-style-type: none"> Tablet (50 mg, 100 mg, 150 mg, 200 mg): Two tablets per day
Vesanoid	tretinoin capsule	
Vitrakvi	larotrectinib sulfate capsule and solution	<ul style="list-style-type: none"> 20 mg/ml solution: 10 mls per day 25 mg: Six capsules per day 100 mg: Two capsules per day
Vizimpro	dacomitinib tablet	<ul style="list-style-type: none"> Tablet (15 mg, 30 mg, 45 mg): One tablet per day
Vonjo	pacritinib capsul	<ul style="list-style-type: none"> 100mg: Four capsules per day
Voranigo	vorasidenib tablet	<ul style="list-style-type: none"> 10 mg: 60 tablets per 30 days 40 mg: 30 tablets per 30 days
Votrient	pazopanib tablet	<ul style="list-style-type: none"> 200 mg: Four tablets per day
Welireg	belzutifan tablet	<ul style="list-style-type: none"> 40 mg: Three tablets per day
Xalkori	crizotinib capsule/ coated pellet capsule	<ul style="list-style-type: none"> Capsule (200 mg, 250 mg): Four capsules per day 20 mg, 50 mg coated pellet capsule: Four coated pellet capsules per day 150 mg coated pellet capsule: Six coated pellet capsules per day
Xospata	gilteritinib tablet	<ul style="list-style-type: none"> 40 mg: Three tablets per day

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCONC103**

**ANTINEOPLASTICS AGENTS
ANTI-CANCER MEDICATIONS –
SELF-ADMINISTERED**

See [Appendix A](#) for medications covered by policy

Brand Name	Generic Name/Dosage form	Quantity Limit
Xpovio	selinexor tablet/ tablet dose packs	<ul style="list-style-type: none"> • 40 mg/week: 4 tablets per 28 days • 60 mg/week: 4 tablets per 28 days • 80 mg/week: 8 tablets per 28 days • 100 mg/week: 8 tablets per 28 days • 120 mg/week: 24 tablets per 28 days • 160 mg/week: 32 tablets per 28 days
Xtandi	enzalutamide capsule	<ul style="list-style-type: none"> • 40 mg capsule: Four capsules per day • 40 mg tablet: Four tablets per day • 80 mg tablet: Two tablets per day
Yonsa	abiraterone acet, submicronized	
Zejula	niraparib tablet	<ul style="list-style-type: none"> • 100 mg/200 mg/300 mg tablets: One tablet per day
Zelboraf	vemurafenib tablet	<ul style="list-style-type: none"> • 240 mg: Eight tablets per day
Zolinza	vorinostat tablet	<ul style="list-style-type: none"> • 100 mg: Four capsules per day
Zydelig	idelalisib tablet	<ul style="list-style-type: none"> • Tablet (100 mg, 150 mg): Two tablets per day
Zykadia	ceritinib tablet	<ul style="list-style-type: none"> • 150 mg: Three tablets per day
Zytiga*	abiraterone acetate tablet	

*Coverage of the brand formulation of these drug entities requires meeting clinical criteria outlined in this policy in addition to the criteria outlined in the Formulary and Quantity Exceptions Policy.