JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTHCARE	Johns Hopkins HealthCare LLC **Pharmacy Public** **Pharmacy Management Drug Policies**	*Policy Number*	MEDS150
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	Subject **Scemblix**	*Revision Date*	07/20/2022
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This document applies to the following Participating Organizations:

Priority Partners

Keywords: Scemblix

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I. POLICY

1. **Scemblix** (asciminib) will require prior authorization for appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.
    1. PPMCO members are subject to the Priority Partners formulary, available at www.ppmco.org.
    2. USFHP members are subject to prior authorization criteria, step-edits and days-supply limits outlined in the Tricare Policy Manual. Tricare Policy supersedes JHHC Medical/Pharmacy Policies. Tricare limits may be accessed at: http://pec.ha.osd.mil/formulary_search.php?submenuheader=1

II. POLICY CRITERIA

A. **Scemblix** may be approved for patients meeting the following:
    1. Chronic Myeloid Leukemia
        a. Patient is 18 years of age or older
        b. Documentation has been submitted showing the following:
            I. Diagnosis of Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML)
            II. Ph+ CML is in chronic phase
            III. Patient has had trial and inadequate response with at least two or more tyrosine kinase inhibitors, such as Gleevec (imatinib), Tasigna (nilotinib), Sprycel (dasatinib), or Bosulif (bosutinib)
            IV. Additional requirement:
                i. If the patient has the T315I mutation:
                    A. Documentation has been submitted showing trial and inadequate response to Iclusig (ponatinib), or a clinical rationale for why Iclusig can not be used

III. AUTHORIZATION PERIOD/LIMITATIONS

1. Initial approval will be limited to 6 months of therapy
2. Approval for continuation of therapy may be extended in 6-month intervals with documentation showing the patient has had a beneficial response to treatment with no evidence of unacceptable toxicity or disease progression

IV. EXCLUSIONS

A. Scemblix will not be approved for the following:
   1. Pediatric patients
   2. Any indications or usage that is not FDA-approved, or guideline-supported

B. The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

V. REFERENCES

1. Scemblix [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; October 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: https://www.nccn.org. Accessed June 24 2022.

VI. APPROVALS

Signature on file at JHHC

DATE OF REVISION	SUMMARY OF CHANGE
07/20/2022	Policy Creation

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