

Priority Health Medicare Prior Authorization Criteria (Part D)

Sprycel®

Products affected

- Sprycel®

Details

Covered uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion criteria	N/A
Required medical information	N/A
Age restrictions	N/A
Prescriber restrictions	N/A
Coverage duration	Authorized for one year.
Other criteria	BCR-ALB1 Gene Arrangement, Quantitative PCR must be completed at baseline, then every 3 months to assess response to therapy until complete cytogenic response, then every 3 months for 3 years, then every 3-6 months thereafter. If loss of response to Sprycel occurs, BCR-ABL kinase domain mutation analysis must be done before changing therapy.