STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

OMACETAXINE

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
OMACETAXINE MEPESUCCINATE	SYNRIBO	24243		GPI-10 (2170004010)	

GUIDELINES FOR USE

1. Does the patient have a diagnosis of chronic or accelerated phase chronic myeloid leukemia (CML) and meet **ALL** of the following criteria?
   - The patient is 18 years of age or older
   - The patient had a resistance or intolerance to TWO or more tyrosine kinase inhibitors (e.g., Gleevec, Sprycel, Tasigna, Bosulif, Iclusig)

   If yes, **approve for 12 months by HICL.**
   If no, do not approve.
   DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **OMACETAXINE (Synribo)** requires the following rule(s) be met for approval:
   A. You have chronic or accelerated phase chronic myeloid leukemia (CML: type of blood cell cancer)
   B. You are 18 years of age or older
   C. You had a resistance or intolerance to TWO or more tyrosine kinase inhibitors (such as Gleevec, Sprycel, Tasigna, Bosulif, Iclusig)

   Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Synribo.

REFERENCES

- Synribo [Prescribing Information]. North Wales, PA: Teva Pharmaceuticals USA, Inc.; November 2020.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 04/11/22
Created: 12/12
Client Approval: 03/22
P&T Approval: 05/13