DUVELISIB

Generic	Brand	HICL	GCN	Exception/Other
DUVELISIB	COPIKTRA	45269		

This drug requires a written request for prior authorization.

GUIDELINES FOR USE

1. Is the patient 18 years of age or older?

   If yes, continue to #2.
   If no, do not approve.
   DENIAL TEXT: See the denial text at the end of the guideline.

2. Does the patient have a diagnosis of relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) **AND** meet the following criterion?
   - The patient has received at least two prior therapies for CLL or SLL

   If yes, **approve for 12 months by HICL with a quantity limit of #2 capsules per day.**
   If no, continue to #3.

3. Does the patient have a diagnosis of relapsed or refractory follicular lymphoma (FL) **AND** meet the following criterion?
   - The patient has received at least two prior systemic therapies for FL

   If yes, **approve for 12 months by HICL with a quantity limit of #2 capsules per day.**
   If no, do not approve.
   DENIAL TEXT: The guideline named **DUVELISIB (Copiktra)** requires a diagnosis of relapsed or refractory chronic lymphocytic leukemia (CLL), small lymphocytic lymphoma (SLL), or follicular lymphoma (FL). In addition, the following criteria must be met:
   - The patient is 18 years of age or older

   For patients with relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL), approval requires:
   - The patient has received at least two prior therapies for CLL or SLL

   For patients with relapsed or refractory follicular lymphoma (FL), approval requires:
   - The patient has received at least two prior systemic therapies for FL

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RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Copiktra (duvelisib).

REFERENCES

- Copiktra [Prescribing Information]. Needham, MA: Verastem, Inc.; October 2018.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 01/01/19
Created: 11/18
Client Approval: 11/18
P&T Approval: 10/18