DRUG QUANTITY MANAGEMENT POLICY – PER RX

POLICY: Oncology – Imatinib Drug Quantity Management Policy – Per Rx
- Gleevec® (imatinib tablets – Novartis, generic)

REVIEW DATE: 12/08/2025

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Indication

Imatinib, a tyrosine kinase inhibitor (TKI), is indicated for the treatment of:[1]

- **Acute lymphoblastic leukemia (ALL)**, Philadelphia chromosome positive (Ph+), in adults with relapsed or refractory disease.
- **ALL**, newly diagnosed and Ph+, in combination with chemotherapy in pediatric patients.
- **Aggressive systemic mastocytosis**, in adults, without the D816V c-Kit mutation or with unknown c-Kit mutational status.
- **Chronic myeloid leukemia (CML)**, newly diagnosed and Ph+, in adult and pediatric patients in chronic phase.
- **CML**, Ph+, in blast phase, accelerated phase, or in chronic phase after failure of interferon alfa therapy.
- **Dermatofibrosarcoma protuberans** in adults with unresectable, current, and/or metastatic disease.

- **Gastrointestinal stromal tumors (GIST)**, in patients with Kit (CD117) positive unresectable and/or metastatic malignant disease.
- **GIST**, Kit (CD117) positive, as adjuvant treatment of adults following resection.
- **Hypereosinophilic syndrome and/or chronic eosinophilic leukemia**, adults who have the *FIP1L1-PDGFR* alpha fusion kinase (mutation analysis or fluorescence in situ hybridization demonstration of CICH2 allele deletion) for patients with hypereosinophilic syndrome and/or chronic eosinophilic leukemia who are *FIP1l1-PDGFR* alpha fusion kinase negative or unknown.
- **Myelodysplastic/myeloproliferative diseases**, associated with *PDGFR* gene rearrangements in adults.

Dosing

The Non-Preferred Product dose range of imatinib is 400 to 800 mg per day for its FDA-approved indications.[1] Likewise, literature supports dosing up to 800 mg per day for off-label uses.[2-9] Pediatric dosing is based on body surface area and should not exceed a maximum dose of 600 mg per day.[1] Doses of 400 mg or 600 mg should be administered once daily, whereas a dose of 800 mg should be administered as 400 mg twice a day. For daily dosing of 800 mg and above, the 400 mg tablet should be used to reduce iron exposure.

The imatinib dose should be reduced to manage adverse events, moderate or severe renal impairment, severe hepatic impairment, or drug interactions with cytochrome P450 (CYP)3A4 inhibitors.[1] CYP3A4 inducers may decrease imatinib plasma concentrations. Therefore, the concomitant use of strong CYP3A4 inducers with imatinib should be avoided. However, if imatinib must be administered with a strong CYP3A4 inducer, the dose of imatinib should be increased by at least 50% and clinical response monitored. Doses of up to 1,200 mg per day of imatinib have been studied in combination with CYP3A4 inducers.

Availability

Imatinib (Gleevec, generic) is available in 100 mg and 400 mg tablets.[1] The 100 mg tablets are supplied in bottles of 90, while the 400 mg tablets are supplied in blister packs of 30.

POLICY STATEMENT

This Drug Quantity Management program has been developed to promote the safe, effective, and economic use of imatinib tablets (Gleevec, generic). If the Drug Quantity Management rule is not met for the requested medication at the point of service, coverage will be determined by the Criteria below. All approvals are provided for 1 year in duration, unless otherwise noted below.

Drug Quantity Limit(s)

Product	Strength and Form	Retail Maximum Quantity per Rx	Home Delivery Maximum Quantity Per Rx
Gleevec® (imatinib tablets, generic)	100 mg tablets	180 tablets[α]	540 tablets
	400 mg tablets	60 tablets[β]	180 tablets

[α] 180 tablets is a quantity sufficient for a 30-day supply at retail and a 90-day supply at home delivery at the maximum Non-Preferred Product dose of 600 mg per day; [β] 60 tablets is quantity sufficient for a 30-day supply at retail or a 90-day supply at home delivery at a dose of 800 mg per day.

CRITERIA

Imatinib (Gleevec, generic) 100 mg tablets
No overrides Non-Preferred Product.

Imatinib (Gleevec, generic) 400 mg tablets

1. If the patient is taking a strong cytochrome P450 (CYP)3A4 inducer, approve the requested quantity not to exceed 90 tablets per dispensing at retail or 270 tablets per dispensing at home delivery.
Note: Examples of CYP3A4 inducers include dexamethasone, rifampin, carbamazepine, phenobarbital, phenytoin, rifabutin, rifapentine, and St. John's Wort.

REFERENCES

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7. Guo J, Si L, Kong Y, et al. Phase II, open-label, single-arm trial of imatinib mesylate in patients with metastatic melanoma harboring c-Kit mutation or amplification. *J Clin Oncol*. 2011;29:2904-2909.
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HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	12/13/2023

Annual Revision	No criteria changes.	12/17/2024
Annual Revision	No criteria changes.	12/08/2025