



# Evolut Clinical Guideline 3242 for Scemblix™ (asciminib)

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| <b>Guideline Number:</b><br>Evolut_CG_3242  | <b><u>Applicable Codes</u></b>             |  |
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| <b>Original Date:</b><br>December 2021  | <b>Last Revised Date:</b><br>December 2025 | <b>Implementation Date:</b><br>December 2025 |

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## STATEMENT

### Purpose

To define and describe the accepted indications for Scemblix (asciminib) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

Evolent is responsible for processing all medication requests from network ordering providers. Medications not authorized by Evolent may be deemed as not approvable and therefore not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

## INDICATIONS

**Continuation requests for a not-approvable medication shall be exempt from this Evolent policy provided**

- The member has not experienced disease progression on the requested medication AND
- The requested medication was used within the last year without a lapse of more than 30 days of having an active authorization AND
- Additional medication(s) are not being added to the continuation request.

### Chronic Myeloid Leukemia (CML)

- The member has Philadelphia chromosome-positive or BCR-ABL positive CML and Scemblix (asciminib) may be used as monotherapy in the following:
  - In an adult member with newly diagnosed chronic myeloid leukemia in chronic phase (CP).
  - In an adult member with a documented intolerance, contraindication, or disease progression on 2 or more tyrosine kinase inhibitors including generic imatinib AND one of the following: Tasigna (nilotinib) or Sprycel (dasatinib) OR
  - In an adult member with CML and T315I mutation.

## CONTRAINDICATIONS/WARNINGS

- None

## EXCLUSION CRITERIA

- Disease progression while taking Scemblix (asciminib)
- Scemblix (asciminib) is being used for Philadelphia Chromosome negative or BCR-

ABL negative CML, or in members with the following mutations: A337T, P465S.

- Dosing exceeds single dose limit of Scemblix (asciminib) 80 mg (for Ph+ CML) or 200 mg (for Ph+ CML with the T315I Mutation).
- Treatment exceeds the maximum limit of 60 (20 mg), 240 (40 mg), or 120 (100 mg) tablets/month.
- Investigational use of Scemblix (asciminib) with an off-label indication that is not sufficient in evidence or is not generally accepted by the medical community. Sufficient evidence that is not supported by CMS recognized compendia or acceptable peer reviewed literature is defined as any of the following:
  - Whether the clinical characteristics of the patient and the cancer are adequately represented in the published evidence.
  - Whether the administered chemotherapy/biologic therapy/immune therapy/targeted therapy/other oncologic therapy regimen is adequately represented in the published evidence.
  - Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients. Generally, the definitions of Clinically Meaningful outcomes are those recommended by ASCO, e.g., Hazard Ratio of less than 0.80 and the recommended survival benefit for OS and PFS should be at least 3 months.
  - Whether the experimental design, considering the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover).
  - That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs.
  - That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
  - That abstracts (including meeting abstracts) without the full article from the approved peer-reviewed journals lack supporting clinical evidence for determining accepted uses of drugs.

## **CODING AND STANDARDS**

### **Codes**

- J8999 - asciminib

## Applicable Lines of Business

|                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/>            | CHIP (Children’s Health Insurance Program) |
| <input checked="" type="checkbox"/> | Commercial                                 |
| <input checked="" type="checkbox"/> | Exchange/Marketplace                       |
| <input checked="" type="checkbox"/> | Medicaid                                   |
| <input type="checkbox"/>            | Medicare Advantage                         |

## POLICY HISTORY

| Date          | Summary   |
|---------------|---|
| December 2025 | <ul style="list-style-type: none"> <li>● Converted to new Evolent guideline template</li> <li>● This guideline replaces UM ONC_1455 Scemblix (asciminib)</li> <li>● Updated maximum dosage form quantities in exclusion criteria</li> <li>● Updated references</li> </ul>               |
| December 2024 | <ul style="list-style-type: none"> <li>● Added Evolent disclaimer language</li> <li>● Added Coding Information section with HCPCS code</li> <li>● Updated maximum dosage form quantities in exclusion criteria</li> <li>● Added new indication</li> <li>● Updated references</li> </ul> |

## LEGAL AND COMPLIANCE

### Guideline Approval

#### Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

### Disclaimer

*Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization*

*management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.*

## REFERENCES

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8. AHFS Drug Information. American Society of Health-Systems Pharmacists or Wolters Kluwer Lexi-Drugs. Bethesda, MD 2025.
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11. Current and Resolved Drug Shortages and Discontinuations Reported to the FDA: <http://www.accessdata.fda.gov/scripts/drugshortages/default.cfm>.