



MEDICATION POLICY

Generic Name: Temozolomide

Therapeutic Class or Brand Name: Temodar®

Applicable Drugs (if Therapeutic Class):

Preferred: Temozolomide capsules (generic)

Non-Preferred: Temodar® capsules

Date of Origin: 2/1/13

Date Last Reviewed/Revised: 1/2/18

GPI Code: 2110407000

Prior Authorization Criteria (may be considered medically necessary when criteria I through IV are met):

- I. Documented diagnosis of one of the following conditions A through C:
 - A. Glioblastoma multiforme treated concomitantly with radiotherapy and then as maintenance treatment.
 - B. Refractory anaplastic astrocytoma (i.e. patients who have experienced disease progression on a drug regimen containing nitrosourea and procarbazine).
 - C. Metastatic melanoma.
- II. Minimum age requirement: 18 years old.
- III. Prescriber is an oncologist or hematologist.
- IV. Non-preferred products (i.e. Temodar® capsules) require a documented clinical reason containing details as to why generic temozolomide is not appropriate or is contraindicated.

Exclusion Criteria:

- N/A

Other Criteria:

- N/A

Quantity/Days Supply Restrictions:

- The quantity is limited to a maximum of a 30 day supply per fill.

Approval Length:

Disclaimer: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgment in providing the most appropriate care for their patients.



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- **Authorization:** 1 year.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

Appendix:

N/A

References:

1. Medi-Span.
2. http://www.merck.com/product/usa/pi_circulars/t/temodar_capsules/temodar_pi.pdf.

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Historical Tracking Of Changes Made To Policy	
1/2/2018	1. Removed “ https://www.optumrx.com/rxsol/live/PAGDocs/Guideline_2710.pdf ” from References (link no longer valid).
10/8/2016	1. Changed “N/A” to “Preferred: Temozolomide capsules (generic); Non-Preferred: Temodar® capsules” following Applicable Drugs . 2. Added “IV. Non-preferred products (i.e. Temodar® capsules) require a documented clinical reason containing details as to why generic temozolomide is not appropriate or is contraindicated” under Prior Authorization . 3. Removed “ http://www.connecticare.com/provider/PDFs/Pharmacy/Temodar.pdf ” from References (link no longer valid).
7/10/2015	1. Changed “B. ...nitrosourea procarbazine” to “B. ...nitrosourea and procarbazine” under Prior Authorization Criteria .
1/24/2014	1. Adapted policy to new format . 2. Added GPI Code . 3. Updated references to include Medi-Span.

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