

The following policy is for medication that falls under the Medicare Part D benefit only.

Prior Authorization Group: IRESSA Policy

Drug(s): IRESSA (gefitinib)

Covered Uses: All FDA-approved indications not otherwise excluded from Part D. All criteria in "other criteria" section must be met for coverage.

Required Medical Information: Radiologic reports, start date for Iressa if requested.

Age Restrictions: Restricted to 18 years of age or older

Prescriber Restrictions: Prescribed by oncologist or hematologist

Other Criteria: Extension of therapy is dependent upon radiologic or hematologic and cytogenic documentation of absence of disease progression, and continued benefit from therapy.

Exclusion Criteria: Coverage for Iressa will not be provided if any of the following situations are true:

- new starts, evidence of disease progression while receiving Iressa,
- use in cancers other than Non-Small Cell Lung Cancer (NSCLC),
- doses exceeding package labeling,
- combination use with any other chemotherapeutic agent.

Coverage is not provided for doses exceeding package labeling.

Coverage Duration: 3 months initial approval, 6 months for extension of therapy.