Ayvakit® (avapritinib)
Effective 01/01/2022

Plan	☐ MassHealth ☒ MH UPPL ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit (NLX)		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview
Ayvakit is indicated for unresectable or metastatic gastrointestinal stromal tumor harboring a PDGFRA exon 18 mutation, including PDGFRA D842V mutations in adults and advanced systemic mastocytosis (AdvSM) in adults, including aggressive systemic mastocytosis, systemic mastocytosis with an associated hematological neoplasm, and mast cell leukemia.

Coverage Guidelines
Authorization may be reviewed on a case by case basis for members new to AllWays Health Partners who are currently receiving treatment with Ayvakit excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

<u>Unresectable or metastatic GIST</u>

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Prescriber is an oncologist
3. Appropriate dosing
4. Member has disease harboring a PDGFRA exon 18 mutation (including PDGFRA D842V mutations)
5. Quantity requested is ≤1 tablet/day

Advanced systemic mastocytosis (AdvSM), systemic mastocytosis (SM) with associated hematological neoplasm, mast cell leukemia

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Prescriber is an oncologist or hematologist
3. Appropriate dosing
4. **ONE** of the following:
    a. Member meets **ALL** of the following:
        i. Member has aggressive SM without the D816V c-Kit mutation (as determined by an FDA-approved test) or with c-Kit mutation status unknown
        ii. Physician documentation of inadequate response, adverse reaction, or contraindication to imatinib
    b. D816V c-Kit mutation positive (as determined by an FDA-approved test)
5. Quantity requested is ≤1 tablet/day

Continuation of Therapy

Reauthorization will be granted when physician provides attestation of positive response to therapy.

Limitations

1. Initial approvals and reauthorizations will be granted for 12 months
2. The following quantity limits apply:

Ayvakit tablets	30 tablets per 30 days

Appendix

Appendix A: Exceeding Quantity Limitations

Requests exceeding the quantity limit should be evaluated on a case-by-case basis. If there is compelling rationale for exceeding the quantity limit, please forward to clinical review for case-by-case evaluation (e.g., stability, past approvals at a dose exceeding the quantity limit, specific clinical rationale for dose is documented).

In addition to criteria in the procedure table above, requests exceeding the quantity limit must have **ALL** of the following:

1. Dose is appropriate
2. Dose is consolidated
3. Appropriate clinical rationale for exceeding the quantity limit

References

1. Ayvakit (avapritinib) [prescribing information]. Cambridge, MA: Blueprint Medicines Corporation; June 2021.

Review History

11/17/2021 – Created and Reviewed for Nov P&T. Matched with MH UPPL. Effective 01/01/2022

Disclaimer

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