| Pharmacy Policy Bulletin: J-0882 BCR-ABL Kinase Inhibitors - Commercial and Healthcare Reform | |
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| **Number:** J-0882 | **Category:** Prior Authorization |
| **Line(s) of Business:**<br>☒ Commercial<br>☒ Healthcare Reform<br>☐ Medicare | **Benefit(s):**<br>**Commercial:**<br>**Prior Authorization (1.):**<br>**1.** Miscellaneous Specialty Drugs Oral = Yes w/ Prior Authorization<br><br>**Quantity Limits (1., 2., 3., or 4.):**<br>**1.** Rx Mgmt Quantity Limits = Safety/Specialty<br>**2.** Rx Mgmt Quantity Limits = Safety/Specialty + Dose Opt<br>**3.** Rx Mgmt Quantity Limits = Safety/Specialty + Dose Opt + Watchful<br>**4.** Quantity Limits = QPC = Yes<br><br>**Healthcare Reform:** Not Applicable |
| **Region(s):**<br>☒ All<br>☐ Delaware<br>☐ New York<br>☐ Pennsylvania<br>☐ West Virginia | **Additional Restriction(s):**<br>None |
| **Version:** J-0882-021 | **Original Date:** 06/04/2003 |
| **Effective Date: 08/26/2025** | **Review Date:** 09/17/2025 |

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| **Drugs Product(s):** | • Bosulif (bosutinib)<br>• Danziten (nilotinib)<br>• Gleevec (imatinib)<br>• Iclusig (ponatinib)<br>• Imkeldi (imatinib)<br>• Scemblix (asciminib)<br>• Sprycel (dasatinib)<br>• Tasigna (nilotinib) |
| **FDA-Approved Indication(s):** | • Bosulif (bosutinib)<br>  ○ Treatment of adult and pediatric patients 1 year of age and older with chronic phase (CP) Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML), newly-diagnosed or resistant or intolerant to prior therapy.<br>  ○ Treatment of adult patients with accelerated phase (AP), or blast phase (BP) Ph+ CML with resistance or intolerance to prior therapy.<br>• Danziten (nilotinib)<br>  ○ Treatment of adult patients with newly diagnosed Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase. |

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| | ○ Treatment of adult patients with chronic phase (CP) and accelerated phase (AP) Ph+ CML resistant to or intolerant to prior therapy that included imatinib.<br>• Gleevec (imatinib), Imkeldi (imatinib)<br>○ Treatment of newly diagnosed adults and pediatric patients (1 year or age or older) with Ph+ CML in the chronic phase.<br>○ Treatment of patients with Ph+ CML in blast crisis (BC), AP, or CP after failure of interferon-alpha therapy.<br>○ Treatment of adult patients with relapsed or refractory Ph+ acute lymphoblastic leukemia (ALL).<br>○ Treatment of pediatric patients with newly-diagnosed Ph+ ALL in combination with chemotherapy.<br>○ Treatment of adult patients with myelodysplastic/myeloproliferative diseases (MDS/MPD) associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements.<br>○ Treatment of adult patients with aggressive systemic mastocytosis (ASM) without the D816V c-KIT mutation or with c-Kit mutational status unknown.<br>○ Treatment of adult patients with hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL) who have the FIP1L1-PDGFRα (platelet-derived growth factor receptor) fusion kinase (mutational analysis or FISH demonstration of CHIC2 allele deletion) and for patients with HES and/or CEL who are FIP1L1-PDGFRα fusion kinase–negative or unknown.<br>○ Treatment of adult patients with unresectable, recurrent, and/or metastatic dermatofibrosarcoma protuberans (DFSP).<br>○ Treatment of patients with KIT (CD117)-positive unresectable and/or metastatic malignant gastrointestinal stromal tumors (GIST).<br>○ Adjuvant treatment of adult patients following resection of KIT (CD117)-positive GIST.<br>• Iclusig (ponatinib)<br>○ Treatment of adult patients with newly diagnosed Ph+ ALL, in combination with chemotherapy<br>○ Treatment of adult patients, as monotherapy, with Ph+ ALL for whom no other kinase inhibitors are indicated or T315I-positive Ph+ ALL<br>○ Treatment of adult patients with CP CML with resistance or intolerance to at least two prior kinase inhibitors.<br>○ Treatment of adult patients with AP or BP CML for whom no other kinase inhibitors are indicated.<br>○ Treatment of adult patients with T315I-positive CML (CP, AP, or BP)<br>• Scemblix (asciminib)<br>○ Treatment of adult patients with newly-diagnosed Ph+ CML in CP.<br>○ Treatment of adult patients with previously treated Ph+ CML in CP.<br>○ Treatment of adult patients with Ph+ CML in CP with the T315I mutation.<br>• Sprycel (dasatinib)<br>○ Treatment of newly diagnosed adults with Ph+ CML in CP<br>○ Treatment of adults with CP, AP, or myeloid or lymphoid BP Ph+ CML with resistance or intolerance to prior therapy including imatinib<br>○ Treatment of adults with Ph+ ALL with resistance or intolerance to prior therapy<br>○ Treatment of pediatric patients 1 year of age and older with Ph+ CML in CP<br>○ Treatment of pediatric patients 1 year of age and older with newly diagnosed Ph+ ALL in combination with chemotherapy<br>• Tasigna (nilotinib) |

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| | ○ Treatment of adult and pediatric patients greater than or equal to 1 year of age with newly diagnosed Ph+ CML in CP<br>○ Treatment of adult patients with CP and AP Ph+ CML resistant or intolerant to prior therapy that included imatinib.<br>○ Treatment of pediatric patients greater than or equal to 1 year of age with Ph+ CML-CP and CML-AP resistant or intolerant to prior tyrosine kinase inhibitor (TKI) therapy. |

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| **Background:** | • Bosulif is an oral TKI that works by dual inhibition of the BCR-ABL kinase that promotes CML and the Src-family of kinases (SFK) Src, Lyn, and Hck.<br>• Gleevec (imatinib) and Imkeldi (imatinib) are phenylaminopyrimidine molecules designed to specifically inhibit BCR-ABL tyrosine kinase in CML. BCR-ABL tyrosine kinase is created by the Philadelphia chromosome (Ph+) abnormality in CML and is implicated in the pathogenesis of the disease. Imatinib also inhibits the receptor tyrosine kinases for PDGFR and stem cell factor (SCF), c-Kit and inhibits PDGF-and SCF-mediate cellular events. Imatinib inhibits proliferations and induces apoptosis of GIST cells that express an activated c-Kit mutation.<br>• Iclusig is a kinase inhibitor. Iclusig inhibits the in vitro tyrosine kinase activity of ABL and T315I mutant ABL. It inhibits activity of additional kinases, including members of the VEGFR, PDGFR, FGFR, EPH receptors and SRC families of kinases, and KIT, RET, TIE2, and FLT3. In addition, Iclusig inhibits the in vitro viability of cells expressing the Philadelphia chromosome, including T3151.<br>• Sprycel is a TKI active against BCR-ABL, Src family (Src, Lck, Yes, Fyn), c-Kit, EphA2, and PDGFR-beta. BCR-ABL is the oncogenic tyrosine kinase expressed by Ph+ stem cells, directly involved in the pathogenesis of CML.<br>• Scemblix is an ABL/BCR-ABL1 TKI. It binds to the ABL myristoyl pocket, inhibiting ABL1 kinase activity. Scemblix activity against the T315I mutation in vitro and in animal models.<br>• Tasigna and Danziten are kinase inhibitors and work by inhibiting the proliferation of cells containing the abnormal Philadelphia chromosome. They do this by targeting the production of the BCR-ABL protein, which is produced only by cells containing this abnormal chromosome.<br>• The Philadelphia chromosome may also be referred to as BCR-ABL or chromosome 9 & 22 translocation.<br>• The CD117 gene, officially known as “KIT proto-oncogene receptor tyrosine kinase” (GenBank ID: 3815), is also more commonly known as c-kit, kit, or stem cell factor receptor.<br>• Bosulif oral capsules are available in 50 mg and 100 mg strengths. The 50 mg strength is used in pediatric patients undergoing dose titration.<br>• Scemblix is available as 20 mg, 40 mg, and 100 mg film-coated tablets. Dosing for Scemblix for a diagnosis of Ph+ CML in CP with the T315I mutation is 200 mg twice daily. This dose can be achieved with the 100 mg tablets. If patients experience adverse reactions while taking Scemblix for this indication, 160 mg twice daily is recommended. To achieve this dose, a patient level authorization (PLA) for Scemblix 40 mg is to be entered upon approval of prior authorization for this indication, as described below.<br>• Prescribing considerations:<br>○ Kinase inhibitors should be prescribed under the supervision of a hematologist/oncologist.<br>○ Gleevec and Imkeldi<br>▪ There have been some studies which investigate imatinib for the treatment of pulmonary vein stenosis or pulmonary arterial hypertension. This policy does not address these disease states due to the lack of robust evidence.<br>○ Iclusig |

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| | ▪ Iclusig has a black box warning for arterial occlusion, venous thromboembolism, heart failure, and hepatotoxicity.<br>▪ Iclusig is not indicated and is not recommended for the treatment of patients with newly-diagnosed CP-CML.<br>○ Tasigna and Danziten<br>▪ Tasigna and Danziten have a black box warning for QT prolongation and sudden deaths. |

## Approval Criteria

**I. Initial Authorization**

**A. Bosulif**

When a benefit, coverage of Bosulif may be approved when one (1) of the following criteria are met **(1. or 2.)**:

**1.** The member is 18 years of age and older and meets all of the following criteria **(a. and b.):**
- **a.** The member meets one (1) of the following criteria **(i. or ii.)**:
  - **i.** The member has newly-diagnosed, Ph+ CML (ICD-10: C92.1) in the chronic phase.
  - **ii.** The member has a diagnosis of Ph+ CML (ICD-10: C92.1) in the chronic, accelerated, or blast phase and meets the following criterion **(A))**:
    - **A)** The member has experienced resistance or intolerance to one (1) prior therapy (for example,, imatinib, Sprycel, Tasigna, etc.).
- **b.** If the request is for Bosulif oral capsules, the member meets all of the following criteria **(i. and ii.)**:
  - **i.** The request is for Bosulif 100 mg oral capsules.
  - **ii.** The member has an inability to swallow oral tablets.

**2.** The member is a pediatric patient 1 year of age and older and meets all of the following criteria **(a. and b.)**:
- **a.** The member has a diagnosis of Ph+ CML (ICD-10: C92.1) in the chronic phase and meets one (1) of the following criteria **(i. or ii.)**:
  - **i.** The member is newly-diagnosed.
  - **ii.** The member has experienced resistance or intolerance to one (1) prior therapy (for example, imatinib, Sprycel, Tasigna, etc.).
- **b.** If the request is for Bosulif 100 mg oral capsules, the member has an inability to swallow oral tablets.

**B. Danziten**

When a benefit, coverage of Danziten may be approved when all of the following criteria are met **(1. and 2.):**

**1.** The member is an adult patient diagnosed with Ph+ CML (ICD-10: C92.1) and meets one (1) of the following criteria **(a. or b.)**:
- **a.** The member's CML is in the chronic or accelerated phase and meets the following criterion **(i.):**
  - **i.** The member has experienced resistance or intolerance to prior therapy that included imatinib.
- **b.** The member is newly diagnosed in the chronic phase.

**2.** The member has experienced therapeutic failure or intolerance to plan-preferred, generic nilotinib.

**C. Gleevec (imatinib) or Imkeldi**

**1. Philadelphia chromosome positive (Ph+) Chronic Myeloid Leukemia (CML)** (ICD-10: C92.1)

When a benefit, coverage of Gleevec (imatinib) or Imkeldi may be approved when all of the following criteria are met **(a., b., and c.)**:
- **a.** The member has a diagnosis of Ph+ CML and meets one (1) of the following criteria **(i. or ii.)**:

i. The member is newly diagnosed in the chronic phase.
ii. The member is in blast crisis, the accelerated phase, or the chronic phase after failure of interferon-alpha therapy.

**b.** If the request is for brand Gleevec, the member has experienced therapeutic failure or intolerance to generic imatinib.

**c.** If the request is for Imkeldi, the member meets one (1) of the following criteria **(i. or ii.)**:
i. The member has experienced therapeutic failure or intolerance to plan-preferred generic imatinib tablets.
ii. The member has an inability to swallow oral tablets.

**2. Ph+ Acute Lymphoblastic Leukemia (ALL) (**ICD-10: C91.0)
When a benefit, coverage of Gleevec (imatinib) or Imkeldi may be approved when all of the following criteria are met **(a., b., and c.)**:

**a.** The member has a diagnosis of Ph+ ALL and meets one (1) of the following criteria **(i. or ii.)**:
i. If the member is an adult patient, the member has relapsed or refractory disease.
ii. If the member is a pediatric patient, all of the following criteria are met **(A) and B))**:
**A)** The member is newly diagnosed.
**B)** The member will be using imatinib in combination with a chemotherapy regimen.

**b.** If the request is for brand Gleevec, the member has experienced therapeutic failure or intolerance to generic imatinib.

**c.** If the request is for Imkeldi, the member meets one (1) of the following criteria **(i. or ii.)**:
i. The member has experienced therapeutic failure or intolerance to plan-preferred generic imatinib tablets.
ii. The member has an inability to swallow oral tablets.

**3. Aggressive Systemic Mastocytosis (ASM)** (ICD-10: C96.2)
When a benefit, coverage of Gleevec (imatinib) or Imkeldi may be approved when all of the following criteria are met **(a. through d.):**

**a.** The member is 18 years of age or older.

**b.** The member has a diagnosis of ASM and meets one (1) of the following criteria **(i. or ii.)**:
i. There is documentation that the member does not have D816V c-KIT status.
ii. The member's c-KIT status is unknown.

**c.** If the request is for brand Gleevec, the member has experienced therapeutic failure or intolerance to generic imatinib.

**d.** If the request is for Imkeldi, the member meets one (1) of the following criteria **(i. or ii.)**:
i. The member has experienced therapeutic failure or intolerance to plan-preferred generic imatinib tablets.
ii. The member has an inability to swallow oral tablets.

**4. Gastrointestinal Stromal Tumors (GIST)** (ICD-10: C49.A)
When a benefit, coverage of Gleevec (imatinib) or Imkeldi may be approved when all of the following criteria are met **(a. through d.)**:

**a.** The member is 18 years of age or older.

**b.** The member meets one (1) of the following criteria **(i. or ii)**:
i. The member has a diagnosis of c-KIT (CD117)-positive unresectable and/or metastatic malignant GIST.
ii. Imatinib will be used as adjuvant treatment following resection of c-KIT (CD117)-positive GIST.

**c.** If the request is for brand Gleevec, the member has experienced therapeutic failure or intolerance to generic imatinib.

**d.** If the request is for Imkeldi, the member meets one (1) of the following criteria **(i. or ii.)**:
i. The member has experienced therapeutic failure or intolerance to plan-preferred generic imatinib tablets.

**ii.** The member has an inability to swallow oral tablets.

5. **Dermatofibrosarcoma Protuberans (DFSP)** (ICD-10: C44.90)
   When a benefit, coverage of Gleevec (imatinib) or Imkeldi may be approved when all of the following criteria are met **(a. through d.):**
   **a.** The member is 18 years of age or older.
   **b.** The member has a diagnosis of unresectable, recurrent, or metastatic DFSP.
   **c.** If the request is for brand Gleevec, the member has experienced therapeutic failure or intolerance to generic imatinib.
   **d.** If the request is for Imkeldi, the member meets one (1) of the following criteria **(i. or ii.)**:
      **i.** The member has experienced therapeutic failure or intolerance to plan-preferred generic imatinib tablets.
      **ii.** The member has an inability to swallow oral tablets.

6. **Hypereosinophilic Syndrome/Chronic Eosinophilic Leukemia (HES/CEL)** (ICD-10: D72.1)
   When a benefit, coverage of Gleevec (imatinib) or Imkeldi may be approved when all of the following criteria are met **(a. through d.)**:
   **a.** The member is 18 years of age or older.
   **b.** The member has a diagnosis of HES/CEL.
   **c.** If the request is for brand Gleevec, the member has experienced therapeutic failure or intolerance to generic imatinib.
   **d.** If the request is for Imkeldi, the member meets one (1) of the following criteria **(i. or ii.)**:
      **i.** The member has experienced therapeutic failure or intolerance to plan-preferred generic imatinib tablets.
      **ii.** The member has an inability to swallow oral tablets.

7. **Myeloproliferative Disease (MPD)** (ICD-10: C94.6)
   When a benefit, coverage of Gleevec (imatinib) or Imkeldi may be approved when all of the following criteria are met **(a. through e.)**:
   **a.** The member is 18 years of age or older.
   **b.** The member has a diagnosis of MPD.
   **c.** Disease is associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements.
   **d.** If the request is for brand Gleevec, the member has experienced therapeutic failure or intolerance to generic imatinib.
   **e.** If the request is for Imkeldi, the member meets one (1) of the following criteria **(i. or ii.)**:
      **i.** The member has experienced therapeutic failure or intolerance to plan-preferred generic imatinib tablets.
      **ii.** The member has an inability to swallow oral tablets.

8. **Myelodysplastic Syndrome (MDS)** (ICD-10: D46)
   When a benefit, coverage of Gleevec (imatinib) or Imkeldi may be approved when all of the following criteria are met **(a. through e.)**:
   **a.** The member is 18 years of age or older.
   **b.** The member has a diagnosis of MDS.
   **c.** Disease is associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements.
   **d.** If the request is for brand Gleevec, the member has experienced therapeutic failure or intolerance to generic imatinib.
   **e.** If the request is for Imkeldi, the member meets one (1) of the following criteria **(i. or ii.)**:
      **i.** The member has experienced therapeutic failure or intolerance to plan-preferred generic imatinib tablets.
      **ii.** The member has an inability to swallow oral tablets

**D. Iclusig**

**1. CML** (ICD-10: C92)

When a benefit, coverage of Iclusig may be approved when all of the following criteria are met **(a. and b.)**:

**a.** The member is 18 years of age or older.

**b.** The member meets one (1) of the following criteria **(i., ii., or iii.):**

**i.** The member has T315I-positive CML in the chronic, accelerated, or blast phase.

**ii.** The member has a diagnosis of chronic phase CML and meets the following criterion **(A))**:

**A)** The member has experienced resistance or intolerance to at least two (2) prior kinase inhibitors.

**iii.** The member has a diagnosis of accelerated phase or blast phase CML and the following criterion is met **(A))**:

**A)** No other kinase inhibitor is indicated for the member.

**2. ALL** (ICD-10: C91.0)

When a benefit, coverage of Iclusig may be approved when all of the following criteria are met **(a., b., and c.):**

**a.** The member is 18 years of age or older.

**b.** The member has a diagnosis of Ph+ ALL.

**c.** The member meets one (1) of the following criteria **(i. or ii.)**:

**i.** The member is using Iclusig in combination with chemotherapy and meets the following criterion **(A))**:

**A)** The member is newly diagnosed.

**ii.** The member is using Iclusig as monotherapy and meets one (1) of the following criteria **(A) or B))**:

**A)** No other kinase inhibitor is indicated for the member.

**B)** The member's disease is T315I-positive.

**E. Scemblix**

**1. Ph+ CML** (ICD-10: C92.1)

When a benefit, coverage of Scemblix may be approved when all of the following criteria are met **(a., b., and c.)**:

**a.** The member is 18 years of age or older.

**b.** The member has a diagnosis of Ph+ CML in chronic phase.

**c.** The member meets one (1) of the following criteria **(i., ii., or iii.):**

**i.** The member is newly-diagnosed.

**ii.** The member has been previously treated for Ph+ CML in chronic phase.

**iii.** The member has the T315I mutation.

**2. Quantity Limits**

**a.** When prior authorization is approved for Ph+ T315I+ CML in the chronic phase, Scemblix 40 mg tablets will be authorized for a quantity of 8 tablets per day.
** A separate patient level authorization (PLA) as described in the Quantity Limit criterion will be entered for every request for Scemblix for a diagnosis of Ph+ T315I+ CML in the chronic phase.*

**F. Sprycel (dasatinib)**

**1. CML** (ICD-10: 92.1)

When a benefit, coverage of Sprycel (dasatinib) may be approved when all of the following criteria are met **(a., b., and c.)**:

**a.** The member has a diagnosis of Ph+ CML.

**b.** The member meets one (1) of the following criteria **(i., ii., or iii)**:

**i.** The member is a newly diagnosed adult in the chronic phase.

**ii.** The member is a pediatric patient 1 year of age and older in the chronic phase.

**iii.** The member is in chronic, accelerated, or myeloid or lymphoid blast phase and meets all of the following criteria **(A) and B)):**
**A)** The member is 18 years of age or older.
**B)** The member has experienced resistance or intolerance to prior therapy including imatinib.

**c.** If the request is for brand Sprycel, the member has experienced therapeutic failure or intolerance to generic dasatinib.

**2. ALL** (ICD-10: C91.0)
When a benefit, coverage of Sprycel (dasatinib) may be approved when all of the following criteria are met **(a., b., and c.)**:
**a.** The member has a diagnosis of Ph+ ALL.
**b.** The member meets one (1) of the following criteria **(i. or ii.)**:
**i.** The member is a pediatric patient 1 year of age and older and meets all of the following criteria **(A) and B)):**
**A)** The member is newly diagnosed.
**B)** The member will be using Sprycel (dasatinib) in combination with chemotherapy.
**ii.** The member is an adult patient and meets the following criterion **(A)):**
**A)** The member has experienced resistance or intolerance to prior therapy.
**c.** If the request is for brand Sprycel, the member has experienced therapeutic failure or intolerance to generic dasatinib.

**G. Tasigna (nilotinib)**
When a benefit, coverage of Tasigna (nilotinib) may be approved when one (1) of the following criteria is met **(1. or 2.):**
**1.** The member is an adult patient diagnosed with Ph+ CML (ICD-10: C92.1) and meets one (1) of the following criteria **(a. or b.)**:
**a.** The member's CML is in the chronic or accelerated phase and meets the following criterion **(i.):**
**i.** The member has experienced resistance or intolerance to prior therapy that included imatinib.
**b.** The member is newly diagnosed in the chronic phase.
**2.** The member is a pediatric patient greater than or equal to 1 year of age and meets one (1) of the following criteria **(a. or b.):**
**a.** The member is diagnosed with chronic phase or accelerated phase Ph+ CML and meets the following criterion **(i.):**
**i.** The member has experienced resistance or intolerance to prior tyrosine kinase inhibitor therapy.
**b.** The member is newly diagnosed with Ph+ CML in the chronic phase.

**II. Reauthorization**
When a benefit, reauthorization may be approved when all of the following criteria are met **(A. and B.)**:
**A.** The prescriber attests that the member is tolerating therapy and has experienced a therapeutic response defined as either one (1) of the following **(1. or 2.)**:
**1.** Disease improvement
**2.** Delayed disease progression
**B.** If the request is for brand Gleevec or brand Sprycel, the member has experienced therapeutic failure or intolerance to the AB-rated generic.

**III.** An exception to some or all of the criteria above may be granted for select members and/or circumstances based on state and/or federal regulations.

**IV.** Coverage of oncology medications listed in this policy may be approved on a case-by-case basis per indications supported in the most current NCCN guidelines.

## Limitations of Coverage

**I.** Coverage of drug(s) addressed in this policy for disease states outside of the FDA-approved indications should be denied based on the lack of clinical data to support their effectiveness and safety in other conditions unless otherwise noted in the approval criteria.

**II.** For Commercial or HCR members with a closed formulary, a non-formulary product will only be approved if the member meets the criteria for a formulary exception in addition to the criteria outlined within this policy.

## Authorization Duration

- Commercial and HCR Plans: If approved, up to a 12 month authorization may be granted.

## Automatic Approval Criteria

None

*Refer to J-699 for previous versions.*

**References:**


1. Bosulif [package insert]. New York, NY: Pfizer Labs; September 2023.
2. Danziten [package insert]. Woburn, MA: Azurity Pharmaceuticals, Inc.; November 2024.
3. Gleevec [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; August 2022.
4. Iclusig [package insert]. Cambridge, MA: Ariad Pharmaceuticals Inc.; March 2024.
5. Imkeldi [package insert]. Cambridge, MA: Shorla Oncology Inc.; November 2024.
6. Scemblix [package insert]. East Hanover, NJ: Novartis; October 2024.
7. Sprycel [package insert]. Princeton, NJ: Bristol-Myers Squibb; July 2024.
8. Tasigna [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; February 2024.
9. DRUGDEX System (Micromedex 2.0). Greenwood Village, CO: Truven Health Analytics; 2024.
10. Foster BM, Zaidi D, Young TR, et al. CD117/c-kit in Cancer Stem Cell-Mediated Progression and Therapeutic Resistance. *Biomedicines*. 2018 Mar; 6(1):31.
11. National Comprehensive Cancer Network. NCCN Guidelines Version 2.2025 Chronic Myeloid Leukemia. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cml.pdf. Accessed November 18, 2024.