STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

RUXOLITINIB

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
RUXOLITINIB PHOSPHATE	JAKAFI	38202		GPI-10 (2153756020)	ROUTE ≠ TOPICAL

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Does the patient have a diagnosis of intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis **AND** meet the following criterion?
   - The patient is 18 years of age or older

   If yes, **approve for 6 months by GPID or GPI-10 with a quantity limit of #2 per day.**
   If no, continue to #2.

2. Does the patient have a diagnosis of polycythemia vera and meet **ALL** of the following criteria?
   - The patient is 18 years of age or older
   - The patient has had a trial of or contraindication to hydroxyurea

   If yes, **approve for 12 months by GPID or GPI-10 with a quantity limit of #2 per day.**
   If no, continue to #3.

3. Does the patient have a diagnosis of steroid-refractory acute graft-versus-host disease **AND** meet the following criterion?
   - The patient is 12 years of age or older

   If yes, **approve for 12 months by GPID or GPI-10 with a quantity limit of #2 per day.**
   If no, continue to #4.

4. Does the patient have a diagnosis of chronic graft-versus-host disease and meet **ALL** of the following criteria?
   - The patient is 12 years of age or older
   - The patient has had a failure of one or two lines of systemic therapy

   If yes, **approve for 12 months by GPID or GPI-10 with a quantity limit of #2 per day.**
   If no, do not approve.
   DENIAL TEXT: See the initial denial text at the end of the guideline.

CONTINUED ON NEXT PAGE

RUXOLITINIB

INITIAL CRITERIA (CONTINUED)

INITIAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named **RUXOLITINIB (Jakafi)** requires the following rule(s) be met for approval:

A. You have ONE of the following diagnoses:
   1. Intermediate or high-risk myelofibrosis, (type of bone marrow cancer such as primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis)
   2. Polycythemia vera (a type of blood cancer)
   3. Steroid -refractory acute graft-versus-host disease (a type of short-term immune disorder that did not respond to a type of treatment)
   4. Chronic graft-versus-host disease (a type of long-term immune disorder)

B. **If you have intermediate or high-risk myelofibrosis, such as primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis, approval also requires:**
   1. You are 18 years of age or older

C. **If you have polycythemia vera, approval also requires:**
   1. You are 18 years of age or older
   2. You had a trial of hydroxyurea, unless you have a contraindication (harmful for)

D. **If you have steroid-refractory acute graft-versus-host disease, approval also requires:**
   1. You are 12 years of age or older

E. **If you have chronic graft-versus-host disease, approval also requires:**
   1. You are 12 years of age or older
   2. You had a failure of one or two lines of systemic therapy (treatment that targets the entire body)

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

CONTINUED ON NEXT PAGE

RUXOLITINIB

GUIDELINES FOR USE (CONTINUED)

RENEWAL CRITERIA

NOTE: For the diagnoses of polycythemia vera, acute graft-versus-host disease, or chronic graft-versus-host disease, please refer to the Initial Criteria section.

1. Does the patient have a diagnosis of intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis?

   If yes, continue to #2.
   If no, do not approve.
   DENIAL TEXT: See the renewal denial text at the end of the guideline.

2. Has the patient shown symptom improvement by meeting **ONE** of the following criteria?
   - The patient has a 50% or greater reduction in total symptom score (e.g., Myeloproliferative Neoplasm Symptom Assessment Form [MPN-SAF TSS], modified Myelofibrosis Symptom Assessment Form [MFSAF] v2.0)
   - The patient has a 50% or greater reduction in palpable spleen length
   - The patient has a spleen volume reduction of 35% or greater from baseline

   If yes, **approve for 12 months by GPID or GPI-10 with a quantity limit of #2 per day.**
   If no, do not approve.
   RENEWAL DENIAL TEXT: ***Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.***

   Our guideline named **RUXOLITINIB (Jakafi)** requires the following rule(s) be met for renewal:
   A. You have intermediate or high-risk myelofibrosis, (type of bone marrow cancer such as primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis)
   B. You have shown symptom improvement by meeting ONE of the following:
      1. You have a 50 percent or greater reduction in total symptom score (such as Myeloproliferative Neoplasm Symptom Assessment Form [MPN-SAF TSS], modified Myelofibrosis Symptom Assessment Form [MFSAF] v2.0)
      2. You have a 50 percent or greater reduction in palpable (can be felt by external examination) spleen length
      3. You have a spleen volume reduction of 35 percent or greater from baseline

   (Renewal denial text continued on next page)

CONTINUED ON NEXT PAGE

RUXOLITINIB

RENEWAL CRITERIA (CONTINUED)

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Jakafi.

REFERENCES

- Jakafi [Prescribing Information]. Wilmington, DE. Incyte Corporation; September 2021.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 01/01/22
Created: 12/11
Client Approval: 11/21
P&T Approval: 10/21