FEDRATINIB

Generic	Brand	HICL	GCN	Exception/Other
FEDRATINIB	INREBIC	45953		

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Does the patient have a diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocytemia) myelofibrosis (MF) and meet **ALL** of the following criteria?
   - The patient is 18 years of age or older
   - The patient had a trial of or contraindication to Jakafi (ruxolitinib)

   If yes, **approve for 6 months by HICL with a quantity limit of #4 per day.**
   If no, do not approve.
   INITIAL DENIAL TEXT: The guideline named **FEDRATINIB (Inrebic)** requires a diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocytemia) myelofibrosis (MF). In addition, the following must be met:
   - The patient is 18 years of age or older
   - The patient had a trial of or contraindication to Jakafi (ruxolitinib)

RENEWAL CRITERIA

1. Does the patient have a diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocytemia) myelofibrosis (MF) **AND** meet the following criterion?
   - The patient has had symptom improvement by **ONE** of the following:
     - The patient has a spleen volume reduction of 35% or greater from baseline after 6 months of therapy
     - The patient has a 50% or greater reduction in total symptom score on the modified Myelofibrosis Symptom Assessment Form (MFSAF) v2.0
     - The patient has a 50% or greater reduction in palpable spleen length

   If yes, **approve for 12 months by HICL with a quantity limit of #4 per day.**
   If no, do not approve.
   RENEWAL DENIAL TEXT: The guideline named **FEDRATINIB (Inrebic)** requires a diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocytemia) myelofibrosis (MF). In addition, the following must be met:
   - The patient has had symptom improvement by **ONE** of the following:
     - The patient has a spleen volume reduction of 35% or greater from baseline after 6 months of therapy
     - The patient has a 50% or greater reduction in total symptom score on the modified Myelofibrosis Symptom Assessment Form (MFSAF) v2.0
     - The patient has a 50% or greater reduction in palpable spleen length

CONTINUED ON NEXT PAGE

FEDRATINIB

RATIONALE

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

REFERENCES

- Inrebic [Prescribing Information]. Summit, NJ: Celgene Corporation; August 2019.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 01/01/20
Created: 11/19
Client Approval: 11/19
P&T Approval: 10/19