RUXOLITINIB

Generic	Brand	HICL	GCN	Exception/Other
RUXOLITINIB PHOSPHATE	JAKAFI	38202		

This drug requires a written request for prior authorization.

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Does the patient have a diagnosis of intermediate or high-risk myelofibrosis, such as 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 HICL with a quantity limit of #2 tablets per day.**
   APPROVAL TEXT: Renewal requires symptom improvement [such as a 50 percent or greater reduction in total symptom score on the modified Myelofibrosis Symptom Assessment Form (MFSAF) v2.0], 50 percent or greater reduction in palpable spleen length, or spleen reduction of 35 percent or greater from baseline spleen volume after 6 months of therapy.

   If no, continue to #2.

2. Does the patient have a diagnosis of polycythemia vera **AND** meet 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 HICL with a quantity limit of #2 tablets 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 HICL with a quantity limit of #2 tablets per day.**
   If no, do not approve.
   DENIAL TEXT: See the initial denial text at the end of the guideline.

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RUXOLITINIB

INITIAL CRITERIA (CONTINUED)

INITIAL DENIAL TEXT: The guideline named **RUXOLITINIB (Jakafi)** requires a diagnosis of intermediate or high-risk myelofibrosis, (such as primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis), polycythemia vera, or steroid -refractory acute graft-versus-host disease. The following criteria must also be met:

For patients with intermediate or high-risk myelofibrosis, such as primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis, approval requires:

- The patient is 18 years of age or older

For patients with polycythemia vera, approval requires:

- The patient is 18 years of age or older
- The patient has had a trial of or contraindication to hydroxyurea

For patients with steroid -refractory acute graft-versus-host disease, approval requires:

- The patient is 12 years of age or older

RENEWAL CRITERIA

1. Does the patient have a diagnosis of intermediate or high-risk myelofibrosis, such as 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. Did the patient experience or maintain symptom improvement [such as a 50 percent or greater reduction in total symptom score on the modified Myelofibrosis Symptom Assessment Form (MFSAF) v2.0], 50 percent or greater reduction in palpable spleen length, or spleen reduction of 35 percent or greater from baseline spleen volume after 6 months of therapy?

   If yes, **approve for 12 months by HICL with a quantity limit of #2 tablets per day.**
   If no, do not approve.
   RENEWAL DENIAL TEXT: The guideline named **RUXOLITINIB (Jakafi)** requires a diagnosis of intermediate or high-risk myelofibrosis, such as primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis. In addition, renewal requires that the patient experience or maintain symptom improvement [such as a 50 percent or greater reduction in total symptom score on the modified Myelofibrosis Symptom Assessment Form (MFSAF) v2.0], 50 percent or greater reduction in palpable spleen length, or spleen reduction of 35 percent or greater from baseline spleen volume after 6 months of therapy.

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RATIONALE

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

REFERENCES

- Jakafi [Prescribing Information]. Wilmington, DE. Incyte Corporation; May 2019.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 07/01/19
Created: 12/11
Client Approval: 06/19
P&T Approval: 07/19