

Clinical Policy: Ruxolitinib (Jakafi)

Reference Number: CP.PHAR.98

Effective Date: 03.01.12

Last Review Date: 02.20

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Ruxolitinib (Jakafi®) is a kinase inhibitor.

FDA Approved Indication(s)

Jakafi is indicated for the treatment of:

- Intermediate or high-risk myelofibrosis (MF) in adults, including
 - Primary MF
 - Post-polycythemia vera (post-PV MF)
 - Post-essential thrombocythemia (post-ET MF)
- Polycythemia vera (PCV) in adults who have had an inadequate response to or are intolerant to hydroxyurea
- Steroid-refractory acute graft-versus-host disease (GVHD) in adults and pediatric patients 12 years and older

Policy/Criteria

Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Jakafi is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Myelofibrosis (must meet all):

1. Diagnosis of MF (includes primary MF, post-PV MF, post-ET MF);
2. Prescribed by or in consultation with a hematologist or oncologist;
3. Age \geq 18 years;
4. Request meets one of the following (a or b):*
 - a. Dose does not exceed 50 mg per day;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid/HIM – 6 months

Commercial – Length of Benefit

B. Polycythemia Vera (must meet all):

1. Diagnosis of PCV;

2. Prescribed by or in consultation with a hematologist or oncologist;
3. Age \geq 18 years;
4. Failure of hydroxyurea, peginterferon, or interferon (*see Appendix B*) unless contraindicated or clinically significant adverse effects are experienced;
**Prior authorization may be required for hydroxyurea, peginterferon, and interferon*
5. Request meets one of the following (a or b):*
 - a. Dose does not exceed 50 mg per day;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).
**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:**Medicaid/HIM** – 6 months**Commercial** – Length of Benefit**C. Graft-Versus-Host Disease (must meet all):**

1. Diagnosis of steroid-refractory acute or chronic GVHD post hematopoietic cell transplantation;
2. Prescribed by or in consultation with an oncologist, hematologist, or bone marrow transplant specialist;
3. Age \geq 12 years;
4. Failure of a systemic corticosteroid (e.g., oral prednisone or intravenous methylprednisolone dose equivalent) as defined in Appendix D, unless contraindicated or clinically significant adverse effects are experienced;
5. Request meets one of the following (a or b):*
 - a. Dose does not exceed 20 mg per day;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).
**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:**Medicaid/HIM** – 6 months**Commercial** – Length of Benefit**D. Chronic Myelomonocytic Leukemia and Chronic Myeloid Leukemia (off-label use) (must meet all):**

1. Diagnosis of one of the following (a or b):
 - a. Chronic myelomonocytic leukemia;
 - b. BCR-ABL negative atypical chronic myeloid leukemia;
2. Prescribed by or in consultation with a hematologist or oncologist;
3. Age \geq 18 years;
4. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).
**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:**Medicaid/HIM** – 6 months**Commercial** – Length of Benefit

E. Pediatric B-Cell Acute Lymphoblastic Leukemia (off-label use) (must meet all):

1. Diagnosis of pediatric “Ph-like” B-cell acute lymphoblastic leukemia;
2. Prescribed by or in consultation with a hematologist or oncologist;
3. Age < 18 years;
4. Request is as part of a combination regimen for induction therapy;
5. Disease is positive for mutations associated with the JAK-STAT pathway activation;
6. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).*

**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:

Medicaid/HIM – 6 months

Commercial – Length of Benefit

F. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Jakafi for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a, b, or c):*
 - a. For MF, PCV: New dose does not exceed 50 mg per day;
 - b. For acute GVHD: New dose does not exceed 20 mg per day;
 - c. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:

Medicaid/HIM – 6 months (12 months for MF)

Commercial – Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration	Post-ET MF: post-essential thrombocythemia myelofibrosis
MF: myelofibrosis	Post-PV MF: post-polycythemia vera myelofibrosis
PCV: polycythemia vera	
GVHD: graft-versus-host disease	

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/Maximum Dose
hydroxyurea (Droxia [®] , Hydrea [®])	PCV: Adults: 1000 to 2000 mg PO per day divided into 1 to 3 doses initially. The dose is adjusted as needed to normalize the blood counts of red cells, neutrophils, and platelets.	Varies
Intron A [®] (interferon alfa-2b)	PCV: Varies (off-label use)	Varies
Pegasys [®] , Pegasys ProClick [®] (peginterferon alfa-2a)		
PegIntron [®] , Sylatron [®] (peginterferon alfa-2b)		

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: Steroid Refractoriness or Resistance: Acute and Chronic GVHD (NCCN)

- Acute GVHD
 - Progression of acute GVHD within 3-5 days of therapy onset with ≥ 2 mg/kg/day of prednisone* OR failure to improve within 5-7 days of treatment initiation OR incomplete response after more than 28 days of immunosuppressive treatment including steroids.
- Chronic GVHD
 - Chronic GVHD progression* while on prednisone* at ≥ 1 mg/kg/day for 1-2 weeks OR stable GVHD disease while on ≥ 0.5 mg/kg/day (or 1 mg/kg every other day) of prednisone* for 1-2 months.

**Oral prednisone or IV methylprednisolone dose equivalent. Hematopoietic Cell Transplantation (HCT): Pre-Transplant Recipient Evaluation and Management of Graft-Versus-Host-Disease Version 1.2020. National Comprehensive Cancer Network Guidelines. Available at www.nccn.org. Accessed November 6, 2019.*

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MF	5 mg to 25 mg PO BID	50 mg/day
PCV	10 mg to 25 mg PO BID	50 mg/day
acute GVHD	5 mg to 10 mg PO BID	20 mg/day

VI. Product Availability

Tablets: 5 mg, 10 mg, 15 mg, 20 mg, 25 mg

VII. References

1. Jakafi Prescribing Information. Wilmington, DE: Incyte Corporation; May 2019. Available at: <http://www.jakafi.com>. Accessed November 6, 2019.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed November 6, 2019.
3. Hydroxyurea. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2019. Available at: <http://www.clinicalpharmacology-ip.com/>.
4. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed November 6, 2019.
5. Myeloproliferative Neoplasms Version 3.2019. National Comprehensive Cancer Network Guidelines. Available at www.nccn.org. Accessed November 6, 2019.
6. Hematopoietic Cell Transplantation (HCT): Pre-Transplant Recipient Evaluation and Management of Graft-Versus-Host-Disease Version 1.2020. National Comprehensive Cancer Network Guidelines. Available at www.nccn.org. Accessed November 6, 2019.
7. Myelodysplastic Syndromes Version 1.2020. National Comprehensive Cancer Network Guidelines. Available at www.nccn.org. Accessed November 6, 2019.
8. Pediatric Acute Lymphoblastic Leukemia Version 1.2020. National Comprehensive Cancer Network Guidelines. Available at www.nccn.org. Accessed November 6, 2019.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy converted to new template. Myelofibrosis and PV criteria: specialist requirement added; requests for documentation removed; dose titration and drug interaction details removed; max titrated dose added. Myelofibrosis criteria: intermediate- and high-risk diagnostic criteria added per Tefferi and Gangat; symptom improvement/reduction in spleen size informed by PI clinical trials.	03.01.16	04.16

Reviews, Revisions, and Approvals	Date	P&T Approval Date
PV criteria: initial phlebotomy and splenomegaly requirements, and therapeutic response criteria, informed by Vannucchi/PI clinical trials; initial approval period increased to 6 months to allow for response.		
Initial MF criteria: removed requirements related to age and other safety criteria; clarified unfavorable karyotype; added NCCN compendial indications. Initial PV criteria: removed requirements related to age, and other safety criteria. Re-auth MF and PV: removed reasons to discontinue and other safety criteria, added max dose, extended approval duration from 6 months to 12months.	03.01.17	04.17
1Q18 annual review: Removed request for bloodwork. Removed NCCN off-label use for myelofibrosis. References reviewed and updated.	11.22.17	02.18
1Q 2019 annual review; Commercial and HIM lines of business added; intermediate or high-risk MF is removed to accommodate additional NCCN recommendations; interferons are added to PCV as a failed trial choice per NCCN; references reviewed and updated.	11.13.18	02.19
Criteria added for new FDA indication: steroid-refractory acute graft-versus-host disease; references reviewed and updated.	07.16.19	11.19
1Q 2020 annual review: removed HIM disclaimer for HIM NF drugs; NCCN recommended use for chronic GVHD added with new NCCN guideline update to steroid refractory definitions at Appendix D; additional NCCN uses added for chronic myelomonocytic leukemia, chronic myeloid leukemia, acute lymphoblastic leukemia; references reviewed and updated; continuation approval duration increased to 12 months; references reviewed and updated.	11.19.19	02.20

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering

benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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