SPECIALTY GUIDELINE MANAGEMENT

JAKAFI (ruxolitinib)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications
   A. Jakafi is indicated for treatment of patients with intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis.
   B. Jakafi is indicated for treatment of patients with polycythemia vera who have had an inadequate response to or are intolerant of hydroxyurea.

B. Compendial Uses
   1. Symptomatic low-risk or intermediate-risk 1 myelofibrosis
   2. Accelerated phase or blast phase myelofibrosis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

A. Myelofibrosis
Authorization of 12 months may be granted for the treatment of myelofibrosis.

B. Polycythemia Vera
Authorization of 12 months may be granted for members who have had an inadequate response to or are intolerant of hydroxyurea.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Jakafi [package insert]. Wilmington, DE: Incyte Corporation; March 2016.
2. The NCCN Drugs & Biologics Compendium™ © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed September 27, 2016.
3. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Myeloproliferative Neoplasms. Version 1.2017. https://www.nccn.org/professionals/physician_gls/PDF/mpn.pdf. Accessed September 27.2016.