

# PRIOR AUTHORIZATION POLICY

**POLICY:** Oncology – Jakafi Prior Authorization Policy

- Jakafi® (ruxolitinib tablets – Incyte)

**REVIEW DATE:** 03/31/2021

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## OVERVIEW

Jakafi, an inhibitor of Janus Associated Kinases (JAKs) JAK1 and JAK2, is indicated for treatment of patients with:<sup>1</sup>

- **Graft versus host disease**, acute treatment, in adult and pediatric patients  $\geq 12$  years of age.
- **Myelofibrosis**, intermediate or high risk, including primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis in adults.
- **Polycythemia vera**, in adults who have had an inadequate response to or are intolerant of hydroxyurea.

## Disease Overview

Myelofibrosis, polycythemia vera, and essential thrombocythemia are a group of uncommon heterogeneous disorders involving the hematopoietic system.<sup>2-4</sup> In the US, the prevalence of myelofibrosis, essential thrombocythemia, and polycythemia vera were approximately 13,000, 134,000, and 148,000 cases respectively.<sup>2</sup> It is a cancer that impacts the normal production of red blood cells and involves the replacement of bone marrow by fibrous scar tissue. There is a lack of red blood cells, and an overabundance of white blood cells. The symptom profile in myeloproliferative neoplasms is complex and symptoms vary among the subtype. Patients may experience fatigue, pruritis, weight loss, splenomegaly, and various laboratory abnormalities (e.g., erythrocytosis, thrombocytosis, and leukocytosis). The disease can be slowly progressive and early in the disease process patients may be asymptomatic. However, some patients with this condition may have the disease transform into acute myeloid leukemia which is associated with a poor prognosis. The management of myeloproliferative neoplasms involves identification of specific mutations which guide targeted therapies and have resulted in improvement of disease symptoms. Other treatment are symptom-based.

## Guidelines

Several guidelines by the National Comprehensive Cancer Network (NCCN) address Jakafi.<sup>2</sup>

- **Acute Lymphoblastic Leukemia (ALL):** The NCCN guidelines for pediatric ALL (version 2.2021 – October 22, 2020) recommend Jakafi in a variety of regimens for pediatric patients and young adults with ALL (category 2A).<sup>5</sup> The utility of Jakafi is described primarily in patients in which the mutation/pathway is JAK-related.
- **Graft Versus Host Disease:** The NCCN has guidelines regarding hematopoietic cell transplantation that discuss graft versus host disease (version 1.2021 – January 28, 2021) that include Jakafi.<sup>6</sup> Jakafi is recommended among patients with steroid-refractory chronic graft versus host disease in the acute (category 1) and chronic (category 2A) setting.<sup>6</sup> Supportive data are available.<sup>7-9</sup> A variety of other agents are also recommended such as cyclosporine, tacrolimus, mycophenolate mofetil, Imbruvica® (ibrutinib capsules and tablets), and imatinib.
- **Myelodysplastic Syndromes:** NCCN guidelines for myelodysplastic syndromes (version 3.2021 – January 16, 2021) state that patients with atypical chronic myeloid leukemia with CSF3R or JAK-2 mutations may respond to Jakafi (category 2A).<sup>10</sup> Additionally, in patients with chronic monomyelocytic leukemia 2, benefits have been shown in patients receiving hypomethylating agents with Jakafi (category 2A).

- **Myeloproliferative Neoplasms:** NCCN guidelines for myeloproliferative neoplasms (version 1.2020 – May 21, 2020) recommend Jakafi among patients with lower- and higher-risk myelofibrosis (category 2A).<sup>2</sup> It is also a recommended therapy for patients with low- or high-risk polycythemia vera after other agents (e.g., hydroxyurea) [category 2A].

### **POLICY STATEMENT**

Prior Authorization is recommended for prescription benefit coverage of Jakafi. All approvals are provided for the durations noted below.

**Automation:** The ICD-9/ICD-10 codes for myelofibrosis (ICD-9: 289.83 and ICD-10: D75.81) will be used as part of automation to allow approval of the requested medication.

### **RECOMMENDED AUTHORIZATION CRITERIA**

Coverage of Jakafi is recommended in those who meet the following criteria:

#### **FDA-Approved Indications**

1. **Graft versus Host Disease, Acute.** Approve for 1 year if the patient meets the following criteria (A and B):
  - A) Patient is  $\geq 12$  years of age; AND
  - B) Patient has tried one systemic corticosteroid.
2. **Myelofibrosis (MF), including Primary MF, Post-Polycythemia Vera MF, and Post-Essential Thrombocythemia MF.** Approve for 3 years if the patient is  $\geq 18$  years of age.
3. **Polycythemia Vera.** Approve for 3 years if the patient meets the following criteria (A and B):
  - A) Patient is  $\geq 18$  years of age; AND
  - B) Patient has tried hydroxyurea.

#### **Other Uses with Supportive Evidence**

4. **Acute Lymphoblastic Leukemia.** Approve for 3 years if the patient meets the following criteria (A and B):
  - A) Patient is  $< 21$  years of age; AND
  - B) The mutation/pathway is Janus Associated Kinase-related.
5. **Atypical Chronic Myeloid Leukemia.** Approve for 3 years if the patient meets the following criteria (A or B):
  - A) Patient has a CSF3R mutation; OR
  - B) Patient has a Janus Associated Kinase mutation.
6. **Chronic Monomyelocytic Leukemia-2.** Approve for 3 years if the patient meets the following criteria (A and B):
  - A) Patient is  $\geq 18$  years of age; AND
  - B) Patient is also receiving a hypomethylating agent.

Note: Examples of hypomethylating agents include azacitidine and decitabine.

**7. Graft versus Host Disease, Chronic.** Approve for 1 year if the patient meets the following criteria (A and B):

**A)** Patient is  $\geq 12$  years of age; AND

**B)** Patient has tried one conventional systemic treatment for graft versus host disease.

Note: Examples include systemic corticosteroids (methylprednisolone, prednisone), cyclosporine, tacrolimus, mycophenolate mofetil, Imbruvica® (ibrutinib capsules and tablets), and imatinib.

### **CONDITIONS NOT RECOMMENDED FOR APPROVAL**

Coverage of Jakafi is not recommended in the following situations:

**1.** Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

### **REFERENCES**

1. Jakafi® tablets [prescribing information]. Wilmington, DE: Incyte; January 2020.
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3. Tefferi A. Primary myelofibrosis: 2019 update on diagnosis, risk-stratification and management. *Am J Hematol.* 2018;93(12):1551-1560.
4. Vannucchi AM, Guglielmelli P. What are the current treatment approaches for patients with polycythemia vera and essential thrombocythemia? *Hematology Am Soc Hematol Educ Program.* 2017;2017(1):480-488.
5. The NCCN Pediatric Acute Lymphoblastic Leukemia Clinical Practice Guidelines in Oncology (version 2.2021 – October 22, 2020). © 2020 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed on March 26, 2021.
6. The NCCN Hematopoietic Cell Transplantation (HCT): Pre-Transplant Recipient Evaluation and Management of Graft-Versus-Host Disease Clinical Practice Guidelines in Oncology (Version 1.2021 – January 28, 2021). © 2021 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed on March 26, 2021.
7. Zeiser R, Von Bubnoff N, et al. Ruxolitinib for glucocorticoid-refractory acute graft versus host disease. *N Engl J Med.* 2020;382:1800-1810.
8. Khoury HJ, Langston AA, Kota VK, et al. Ruxolitinib: a steroid sparing agent in chronic graft-versus-host disease. *Bone Marrow Transplant.* 2018;53:826-831.
9. Modi B, Hernandez-Henderson M, Yang D, et al. Ruxolitinib as salvage therapy for chronic graft-versus-host disease. *Biol Blood Marrow Transplant.* 2019;25:265-269.
10. The NCCN Myelodysplastic Syndromes Clinical Practice Guidelines in Oncology (version 3.2021 – January 15, 2021). © 2021 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed on March 26, 2021.