



PRIOR AUTHORIZATION POLICY

- POLICY:** Oncology – Jakafi Prior Authorization Policy
- Jakafi® (ruxolitinib tablets – Incyte)

REVIEW DATE: 03/20/2024

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Jakafi, an inhibitor of Janus Associated Kinases (JAKs) *JAK1* and *JAK2*, is indicated for the following uses:¹

- **Graft versus host disease**, acute treatment of steroid-refractory disease, in patients \geq 12 years of age.
- **Graft versus host disease**, chronic treatment, after failure of one or two lines of systemic therapy in 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.

Guidelines

Jakafi is discussed in guidelines by the National Comprehensive Cancer Network (NCCN):²

- **Graft Versus Host Disease:** NCCN has guidelines regarding hematopoietic cell transplantation that discuss graft versus host disease (version 3.2023 – October 9, 2023) that include Jakafi.³ Jakafi is

recommended among patients with steroid-refractory acute graft versus host disease, or chronic graft versus host disease, after failure of one or two lines of systemic therapy (both category 1).³

- **Myelodysplastic Syndromes:** NCCN guidelines (version 1.2024 – February 12, 2024) recommend Jakafi for patients with chronic myelomonocytic leukemia-2, with hypomethylating agents (HMA) and/or allogeneic hematopoietic stem cell transplant (category 2A).⁴ Jakafi ± HMA is also recommended for myelodysplastic syndrome/myeloproliferative neoplasm with neutrophilia (atypical chronic myeloid leukemia); there is a footnote, which states that rare patients with *CSF3R* or *JAK2* mutations may respond to Jakafi due to their JAK-STAT pathway activation (category 2A).
- **Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions:** NCCN guidelines (version 1.2024 – December 21, 2023) recommend Jakafi for treatment of myeloid/lymphoid neoplasms with eosinophilia and *JAK2* rearrangement in chronic or blast phase (category 2A).⁵ The guidelines also recommend Jakafi for treatment in combination with acute lymphocytic leukemia or acute myeloid leukemia type induction chemotherapy followed by allogeneic hematopoietic stem cell transplantation (if eligible) for lymphoid, myeloid, or mixed phenotype neoplasms with eosinophilia and *JAK2* rearrangement in blast phase (category 2A).
- **Myeloproliferative Neoplasms:** NCCN guidelines (version 1.2024 – December 21, 2023) recommend Jakafi among patients with lower- or higher-risk myelofibrosis (category 2A; category 1 for the initial treatment of higher-risk myelofibrosis).⁶ It is also recommended as “Other Recommended Regimens” for the management of myelofibrosis associated anemia with the presence of symptomatic splenomegaly and/or constitutional symptoms in combination with other medications (category 2A). It is also recommended as “Other Recommended Regimens” for high-risk polycythemia vera as initial treatment (category 2A) and as “Preferred” therapy for patients with hydroxyurea resistance or intolerance (category 1). The guidelines also recommend Jakafi for treatment of essential thrombocythemia for inadequate response or loss of response to hydroxyurea, Pegasys® (peginterferon alfa-2a subcutaneous injection) therapy, or anagrelide as “Useful in Certain Circumstances” (category 2A).
- **Pediatric Acute Lymphoblastic Leukemia:** NCCN guidelines (version 4.2024 – February 7, 2024) recommend Jakafi in a variety of regimens for pediatric patients and young adults with acute lymphoblastic leukemia (category 2A).⁷ The utility of Jakafi is described primarily in patients in which the mutation/pathway is *JAK*-related.
- **T-Cell Lymphoma:** NCCN guidelines (version 2.2024 – March 14, 2024) recommend Jakafi as a single-agent for symptomatic disease as second-line or subsequent therapy for T-cell prolymphocytic leukemia (category 2A).⁸ It is also recommended for T-cell large granular lymphocytic leukemia if the patient had no response to first-line therapy, or if patient had progressive or refractory disease after first-line therapy (category 2A).⁸

POLICY STATEMENT

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

- **Jakafi® (ruxolitinib tablets (Incyte)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indications

- 1. Graft versus Host Disease, Acute.** Approve for 1 year if the patient meets BOTH of the following (A and B):
 - A) Patient is ≥ 12 years of age; AND
 - B) Patient has tried one systemic corticosteroid.
- 2. Graft versus Host Disease, Chronic.** Approve for 1 year if the patient meets BOTH of the following (A and B):
 - A) Patient is ≥ 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, tablets, and oral solution), and imatinib.
- 3. Myelofibrosis (MF), including Primary MF, Post-Polycythemia Vera MF, and Post-Essential Thrombocythemia MF.** Approve for 1 year if the patient is ≥ 18 years of age.
- 4. Polycythemia Vera.** Approve for 1 year if the patient meets BOTH of the following (A and B):
 - A) Patient is ≥ 18 years of age; AND
 - B) Patient has tried hydroxyurea, Pegasys (peginterferon alfa-2a subcutaneous injection), or Besremi (ropeginterferon alfa-2b-njft subcutaneous injection).

Other Uses with Supportive Evidence

- 5. Acute Lymphoblastic Leukemia.** Approve for 1 year if the patient meets BOTH of the following (A and B)
 - A) Patient is < 21 years of age; AND
 - B) The mutation/pathway is Janus Associated Kinase (*JAK*)-related.
- 6. Atypical Chronic Myeloid Leukemia.** Approve for 1 year if the patient meets one of following (A or B):
 - A) Patient has a *CSF3R* mutation; OR
 - B) Patient has a Janus Associated Kinase 2 (*JAK2*) mutation.
- 7. Chronic Myelomonocytic Leukemia-2.** Approve for 1 year if the patient meets BOTH of the following (A and B):

- A) Patient is ≥ 18 years of age; AND
- B) Patient is also receiving a hypomethylating agent.
Note: Examples of hypomethylating agents include azacitidine and decitabine.

8. Essential Thrombocythemia. Approve for 1 year if the patient meets BOTH of the following (A and B):

- A) Patient is ≥ 18 years of age; AND
- B) Patient has tried hydroxyurea, Pegasys (peginterferon alfa-2a subcutaneous injection), or anagrelide.

9. Myeloid or Lymphoid Neoplasms. Approve for 1 year if the patient meets ALL of the following (A, B, and C):

- A) Patient is ≥ 18 years of age; AND
- B) Patient has eosinophilia; AND
- C) The tumor has a Janus Associated Kinase 2 (*JAK2*) rearrangement.

10. T-Cell Lymphoma. Approve for 1 year if the patient meets ALL of the following (A, B, and C):

- A) Patient is ≥ 18 years of age; AND
- B) Patient has one of the following (i or ii):
 - i. T-cell prolymphocytic leukemia; OR
 - ii. T-cell large granular lymphocytic leukemia; AND
- C) Patient has tried at least one systemic regimen.

Note: Examples of a systemic regimen include one or more of the following products: methotrexate, corticosteroids, cyclosporine, Lemtrada (alemtuzumab intravenous infusion), fludarabine, mitoxantrone, or cyclophosphamide.

CONDITIONS NOT COVERED

- **Jakafi® (ruxolitinib tablets (Incyte)**

is(are) considered experimental, investigational, or unproven for ANY other use(s).

REFERENCES

1. Jakafi® tablets [prescribing information]. Wilmington, DE: Incyte; September 2021.
2. The NCCN Drugs and Biologics Compendium. © 2024 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed March 15, 2024. Search term: ruxolitinib.
3. The NCCN Hematopoietic Cell Transplantation Clinical Practice Guidelines in Oncology (version 3.2023 – October 9, 2023). © 2023 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on March 13, 2024.
4. The NCCN Myelodysplastic Syndromes Clinical Practice Guidelines in Oncology (version 1.2024–February 12, 2024). © 2024 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on March 13, 2024.
5. The NCCN Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions Clinical Practice Guidelines in Oncology (version 1.2024 – December 21, 2023). © 2023 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed March 13, 2024.
6. The NCCN Myeloproliferative Neoplasms Clinical Practice Guidelines in Oncology (version 1.2024 – December 21, 2023). © 2023 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on March 15, 2024.

7. The NCCN Pediatric Acute Lymphoblastic Leukemia Clinical Practice Guidelines in Oncology (version 4.2024 – February 7, 2024). © 2024 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on March 15, 2024.
8. The NCCN T-Cell Lymphoma Clinical Practice Guidelines in Oncology (version 2.2024 – March 14, 2024). © 2024 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on March 15, 2024.

Type of Revision	Summary of Changes	Review Date
Annual Revision	Polycythemia Vera: Pegasys (peginterferon alfa-2a subcutaneous injection) was added to the list of agents that patient has tried; previously it was just a trial of hydroxyurea.	03/22/2023
Annual Revision	Polycythemia Vera: Besremi (ropeginterferon alfa-2b-njft subcutaneous injection) was added to the list of medications that the patient has tried. Previously, it was just a trial of hydroxyurea or Pegasys (peginterferon alfa-2a subcutaneous injection). T-Cell Lymphoma: Condition of approval and criteria were added to Other Uses With Supportive Evidence.	03/20/2024

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