



MEDICATION POLICY

Generic Name: Ruxolitinib

Therapeutic Class or Brand Name: Jakafi®

Applicable Drugs (if Therapeutic Class): N/A

Date of Origin: 2/1/13

Date Last Reviewed/Revised: 12/19/17

GPI Code: 2153756020

Prior Authorization Criteria (may be considered medically necessary when criteria I through III are met):

- I. Documented diagnosis of one of the following conditions A or B AND must meet criteria listed under applicable diagnosis:
 - A. Myelofibrosis, including but not limited to primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis.
 - B. Polycythemia vera AND criterion 1 is met:
 1. Documented inadequate response or intolerance to hydroxyurea.
- II. Minimum age requirement: 18 years old.
- III. Prescriber is an oncologist or a hematologist.

Exclusion Criteria:

- N/A

Other Criteria:

- N/A

Quantity/Days Supply Restrictions:

- Quantities of up to 60 tablets per 30 days.

Approval Length:

- **Authorization:** 1 year.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

Disclaimer: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgment in providing the most appropriate care for their patients.



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Appendix:

N/A

References:

1. <http://blue.regence.com/trgmedpol/drugs/dru268.pdf>.
2. [Medi-Span](#).
3. <http://www.jakafi.com/pdf/prescribing-information.pdf>.

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Historical Tracking Of Changes Made To Policy	
12/19/2017	1. Policy reviewed: no changes made.
10/7/2016	1. Updated “ http://www.incyte.com/products/uspi_jakafi.pdf ” to “ http://www.jakafi.com/pdf/prescribing-information.pdf ” under References.
5/14/2015	1. Changed “Documented diagnosis of Myelofibrosis, including but not limited to primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis” to “Documented diagnosis of one of the following conditions A or B AND must meet criteria listed under applicable diagnosis: A. Myelofibrosis, including but not limited to primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis; B. Polycythemia vera AND criterion 1 is met: Documented inadequate response or intolerance to hydroxyurea” under Prior Authorization Criteria.
1/3/2014	1. Adapted policy to new format. 2. Added GPI Code. 3. Changed Quantity/Days Supply Restrictions from “60 tablets per 30 days” to “Quantities of up to 60 tablets per 30 days”. 4. Updated references to include Medi-Span.

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