MEDICATION POLICY:
Jakafi®

Generic Name: Ruxolitinib

Therapeutic Class or Brand Name: Jakafi®

Applicable Drugs (if Therapeutic Class): N/A

GPI Code: 2153756020

Preferred: N/A

Non-preferred: N/A

Date of Origin: 2/1/2013

Date Last Reviewed / Revised: 2/5/2019

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.

Appendix

N/A

REFERENCES

1. Medi-Span®.
2. http://www.jakafi.com/pdf/prescribing-information.pdf ,

HISTORICAL TRACKING OF CHANGES MADE TO POLICY

Date	Notes/Changes
2/5/2019	1. **Deleted** obsolete URL **under References** item #1 http://blue.regence.com/trgmedpol/drugs/dru268.pdf.
12/19/2017	1. Policy reviewed: no changes.
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.