Generic Name: Pacritinib

Therapeutic Class or Brand Name: Vonjo ®

Applicable Drugs (if Therapeutic Class): Click or tap here to enter text.

Preferred: N/A

Non-preferred: N/A

Date of Origin: 8/29/2022

Date Last Reviewed / Revised: 10/19/2024

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I through V are met)

I. Documentation of one of the following diagnoses A through D AND must meet all criteria listed under the applicable diagnosis:

FDA-Approved Indication(s)

A. Intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis and criteria i and ii are met:

i. Documentation of thrombocytopenia (platelet count below 50 × 10^9/L).

ii. Physician attestation stating that the patient is not a transplant candidate or that the patient does not wish to pursue allogenic hematopoietic cell transplant.

Other Uses With Supportive Evidence

B. Lower-risk myelofibrosis and criteria i and ii are met:

i. Documentation of disease-related symptoms.

ii. Platelet count below 50 × 10^9/L.

C. Myelofibrosis associated anemia and criteria i and ii are met:

i. Documentation of splenomegaly and/or disease-related symptoms.

ii. Documentation of anemia.

D. Myeloproliferative neoplasm and criteria i and ii are met:

i. Documentation of myeloproliferative neoplasm with splenomegaly and/or disease-related symptoms.

ii. Used in combination with a hypomethylating agent (ex. azacitidine or decitabine).

II. Minimum age requirement: 18 years old.

III. Treatment must be prescribed by or in consultation with an oncologist or hematologist.

IV. Request is for a medication with the appropriate FDA labeling, or its use is supported by current clinical practice guidelines.

V. Refer to the plan document for the list of preferred products. If the requested agent is not listed as a preferred product, must have documented treatment failure or contraindication to the preferred product(s).

Exclusion Criteria

- Concomitant use of strong CYP3A4 inhibitors or inducers.

Other Criteria

- N/A

Quantity / Days Supply Restrictions

- Quantities of up to 120 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. Vonjo (pacritinib). Prescribing information. CTI BioPharma Corporation; Seattle, WA. August 2023. Accessed October 19, 2024. https://www.ctibiopharma.com/VONJO_USPI.pdf
2. Mascarenhas J, Hoffman R, Talpaz M, et al. Pacritinib vs best available therapy, including ruxolitinib, in patients with myelofibrosis: a randomized clinical trial. *JAMA Oncol.* 2018;4(5):652-659.
3. National Comprehensive Cancer Network (NCCN) Guidelines for Myeloproliferative Neoplasms Version 2.2024. Updated August 8, 2024. Accessed October 19, 2024. https://www.nccn.org/professionals/physician_gls/pdf/mpn.pdf

to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.