Health Alliance™

Pharmacy Drug Policy & Procedure

Policy Name:	**Jakafi (ruxolitinib)**	**Policy #:**	**2417P**

Purpose of the Policy

The purpose of this policy is to define coverage criteria for Jakafi.

Statement of the Policy

Health Alliance Medical Plans will approve the use of Jakafi (ruxolitinib) under the specialty pharmacy benefit if the following criteria are met.

Criteria

1. Coverage Criteria for Acute Graft versus Host Disease (aGVHD)

1.1 Documented diagnosis of steroid-refractory acute graft versus host disease

1.2 Age 12 years and older

2. Coverage Criteria for Chronic Graft versus Host Disease (cGVHD)

2.1 Documented diagnosis of cGVHD

2.2 Age 12 years or older

2.3 Failure of at least one line of systemic therapy (such as prednisone, cyclosporine, tacrolimus)

3. Coverage Criteria for Myelofibrosis

3.1 Review completed by eviCore. See pharmacy policy 2599, **Oncology Regimen Review**

4. Coverage Criteria for Polycythemia Vera

4.1 Review completed by eviCore. See pharmacy policy 2599, **Oncology Regimen Review**

5. Approval Period

5.1 12 months

CPT Codes

References

1. Jakafi (ruxolitinib) [prescribing information]. Wilmington, DE: Incyte Corporation; January 2023.
2. Zeiser R, von Bubnoff N, Butler J, et al. Ruxolitinib for Glucocorticoid-Refractory Acute Graft-versus-Host Disease. N Engl J Med 2020; 382: 1800.
3. Martin PJ, Rizzo JD, Wingard JR, et al. First- and second-line systemic treatment of acute graft-versus-host disease: recommendations of the American Society of Blood and Marrow Transplantation. Biol Blood Marrow Transplant 2012; 18:1150.
4. Escamilla Gómez V, García-Gutiérrez V, López Corral L, et al. Ruxolitinib in refractory acute and chronic graft-versus-host disease: a multicenter survey study. Bone Marrow Transplant 2020; 55:641.
5. Yang W, Zhu G, Qin M, et al. The Effectiveness of Ruxolitinib for Acute/Chronic Graft-versus-Host Disease in Children: A Retrospective Study. Drug Des Devel Ther 2021; 15:743.
6. Arora M, Cutler CS, Jagasia MH, et al. Late Acute and Chronic Graft-versus-Host Disease after Allogeneic Hematopoietic Cell Transplantation. Biol Blood Marrow Transplant 2016; 22:449.

Created Date: 02/03/21
Effective Date: 02/03/21
Posted to Website: 01/01/22
Revision Date: 02/05/25

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