Drug Coverage Policy

Effective Date 5/15/2025
Coverage Policy Number.....IP0318
Policy Title.....Jakafi

Oncology - Jakafi

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 where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. 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.

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 ≥ 12 years of age.
- **Graft-versus-host disease**, chronic treatment, after failure of one or two lines of systemic therapy in patients ≥ 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 from the National Comprehensive Cancer Network (NCCN):[2]

- **Graft-Versus-Host Disease:** NCCN guidelines for hematopoietic cell transplantation discuss graft-versus-host disease (version 2.2024 – August 30, 2024) and include Jakafi.[3] Jakafi is recommended as additional therapy in conjunction with systemic corticosteroids for adults and pediatric patients ≥ 12 years old 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).
- **Myelodysplastic Syndromes:** NCCN guidelines (version 2.2025 – January 17, 2025) recommend Jakafi for patients with chronic myelomonocytic leukemia-2, with hypomethylating agents (HMA) and/or allogenic hematopoietic stem cell transplant for symptom management or splenomegaly (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 2.2024 – June 19, 2024) 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 2.2024 – August 8, 2024) 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 a recommended as "useful in certain circumstances" for high-risk polycythemia vera as initial treatment (category 2A) and as "preferred regimen" for patients with hydroxyurea resistance or intolerance (category 1). There is a footnote that states Jakafi may have activity after inadequate response or loss of response to other agents besides hydroxyurea. 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), or anagrelide as "useful in certain circumstances" (category 2A). JAK inhibitors are also recommended for accelerated or blast phase myeloproliferative neoplasms for the palliation of splenomegaly or other disease-related symptoms (category 2A). Some examples of disease-related symptoms of myeloproliferative neoplasms include fatigue, fever, night sweats, weight loss, abdominal discomfort, splenomegaly, thrombocytosis, or leukocytosis.
- **Pediatric Acute Lymphoblastic Leukemia:** NCCN guidelines (version 2.2025 – December 16, 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 as "other recommended regimen" (category 2A) and T-cell large granular lymphocytic leukemia (category 2A).[8] Jakafi is also recommended as "other recommended regimens" for peripheral T-cell lymphomas as initial therapy and second-line and subsequent therapy (category 2B), for breast implant-associated anaplastic large cell lymphoma as second-line and subsequent therapy for relapsed/refractory disease (category

2B), and for hepatosplenic T-cell lymphoma for refractory disease after two first-line therapy regimens (category 2B).

Coverage Policy

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

Jakafi is considered medically necessary when ONE of the following is met:

FDA-Approved Indication

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), Rezurock (belumosudil tablet), Niktimvo (axatilimab-csfr intravenous infusion), pentostatin, rituximab, Orencia (abatacept intravenous infusion), hydroxychloroquine, 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. **Accelerated or Blast Phase Myeloproliferative Neoplasm**. 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 at least one disease-related symptom.
   Note: Examples of disease-related symptoms include: fatigue, fever, night sweats, weight loss, abdominal discomfort, splenomegaly, thrombocytosis, or leukocytosis.

6. **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.

7. **Atypical Chronic Myeloid Leukemia.** Approve for 1 year if the patient meets ONE of following (A or B):

Note: This includes a patient who has myelodysplastic syndrome/myeloproliferative neoplasm with neutrophilia.
A) Patient has a *CSF3R* mutation; OR
B) Patient has a Janus Associated Kinase 2 (*JAK2*) mutation.

8. **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.

9. **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.

10. **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.

11. **T-Cell Lymphoma**. 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 meets ONE of the following (i or ii):
       i. Patient has peripheral T-cell lymphoma; OR
       ii. Patient meets BOTH of the following: (a and b):
          a) Patient has ONE of the following [(1), (2), (3), or (4)]:
             (1)T-cell prolymphocytic leukemia; OR
             (2)T-cell large granular lymphocytic leukemia; OR
             (3) Hepatosplenic T-cell lymphoma; OR
             (4) Breast implant-associated anaplastic large cell lymphoma; AND
          b) 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.

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Jakafi for any other use is considered not medically necessary. Criteria will be updated as new published data are available.

References

1. Jakafi® tablets [prescribing information]. Wilmington, DE: Incyte; January 2023..
2. The NCCN Drugs and Biologics Compendium. © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed February 17, 2025. Search term: ruxolitinib.
3. The NCCN Hematopoietic Cell Transplantation Clinical Practice Guidelines in Oncology (version 2.2024 – August 30, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on February 7, 2025.
4. The NCCN Myelodysplastic Syndromes Clinical Practice Guidelines in Oncology (version 2.2025 – January 17, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on February 17, 2025.
5. The NCCN Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions Clinical Practice Guidelines in Oncology (version 2.2024 – June 19, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed February 7, 2025.
6. The NCCN Myeloproliferative Neoplasms Clinical Practice Guidelines in Oncology (version 2.2024 – August 8, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on February 7, 2025.
7. The NCCN Pediatric Acute Lymphoblastic Leukemia Clinical Practice Guidelines in Oncology (version 2.2025 – December 16, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on February 17, 2025.
8. The NCCN T-Cell Lymphoma Clinical Practice Guidelines in Oncology (version 1.2025 – November 11, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on February 17, 2025.

Revision Details

Type of Revision	Summary of Changes	Date
Annual Revision	**Updated title from** "Jakafi (ruxolitinib) for Non-Oncology Indications " **to** "Oncology – Jakafi" **Graft versus Host Disease, Acute.** **Updated from** "Documentation of failure, contraindication, or intolerance to ONE systemic corticosteroid" **to** "Patient has tried one systemic corticosteroid" **Graft versus Host Disease, Chronic.** **Updated from** "Documentation of failure, contraindication, or intolerance to ONE conventional systemic treatment for grapft-versus-host-disease" **to "**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), Rezurock (belumosudil tablet), Niktimvo (axatilimab-csfr intravenous infusion), pentostatin, rituximab, Orencia (abatacept intravenous infusion), hydroxychloroquine, and imatinib."	05/15/2025

	Added criteria for: Myelofibrosis (MF), including Primary MF, Post-Polycythemia Vera MF, and Post-Essential Thrombocythemia MF, Polycythemia Vera, Accelerated or Blast Phase Myeloproliferative Neoplasm, Acute Lymphoblastic Leukemia, Atypical Chronic Myeloid Leukemia, Chronic Myelomonocytic Leukemia-2, Essential Thrombocythemia, Myeloid or Lymphoid Neoplasms, T-Cell Lymphoma.	

The policy effective date is in force until updated or retired.