Original Effective Date: 07/01/2019
Current Effective Date: 06/20/2025
Last P&T Approval/Version: 04/30/2025
Next Review Due By: 04/2026
Policy Number: C17367-A

Jakafi (ruxolitinib)

PRODUCTS AFFECTED

Jakafi (ruxolitinib)

COVERAGE POLICY

Coverage for services, procedures, medical devices, and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:
Myelofibrosis, Polycythemia Vera, Graft-Versus-Host Disease

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by-case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

A. MYELOFIBROSIS:
   1. Documented diagnosis of primary myelofibrosis, post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis
      AND

2. Documentation member has intermediate or high-risk disease as defined by possessing TWO or more of the following criteria: Age > 65, Documented Hemoglobin < 10g / Dl, Documented WBC > 25 x 10^9 / L, Circulating Blasts ≥ 1% OR Presence of Constitutional Symptoms (weight loss > 10% from baseline or unexplained fever or excessive sweats persisting for more than 1 month)
   AND
3. Documentation of baseline complete blood count (CBC) with platelet count of at least 50 X 10^9 / L prior to initiating therapy
   AND
4. Documentation that member is ineligible for allogeneic hematopoietic cell transplantation (HCT)
   AND
5. Documentation of baseline assessment of disease (e.g., spleen size, symptoms, Total Symptom Score as measured by the modified Myelofibrosis Symptom Assessment Form (MFSAF)) [DOCUMENTATION REQUIRED]

B. POLYCYTHEMIA VERA:

1. Documented diagnosis of polycythemia vera and member is considered HIGH RISK (>60 years old OR member has a history of thrombosis)
   AND
2. Documentation that member is concurrently on standard of care (low-dose aspirin and phlebotomy to maintain hematocrit <45%) or has a labeled contraindication to these therapies.
   AND
3. Documentation of a baseline platelet count of at least 50,000 cells/mm3 [DOCUMENTATION REQUIRED]
   AND
4. Documentation of baseline palpable spleen length or spleen volume to be used as a measure for therapy efficacy during reauthorization [DOCUMENTATION REQUIRED]
   AND
5. Documented history of trial (14 days minimum at maximum tolerable doses) and failure or inadequate response, labeled contraindication or serious side effects to hydroxyurea AND pegylated interferon (ropeginterferon or peginterferon) *NOTE: Treatment failure is defined as inadequate control of PV-associated symptoms or the inability of cytoreductive therapy to maintain hematocrit <45% (with or without ongoing phlebotomy) without causing severe cytopenias.*
   AND
6. Documentation that member has markedly symptomatic splenomegaly or severe, protracted pruritus or Post-PV myelofibrosis with indications that are expected to be improved by ruxolitinib therapy

C. ACUTE GRAFT VS. HOST DISEASE:

1. Documented diagnosis of acute graft v. host disease Grades II–IV (Mount Sinai Acute GVHD International Consortium [MAGIC] criteria)
   AND
2. Prescriber attests that the member is steroid refractory defined as: disease that progressed after 3 days of ≥2 mg/kg/day of methylprednisolone or equivalent, disease that failed to improve after 7 days of ≥2 mg/kg/day of methylprednisolone or equivalent, were treated with ≥1 mg/kg/day of methylprednisolone for skin GVHD or skin plus upper gastrointestinal (GI) GVHD and developed disease in an additional organ OR were unable to achieve a 50% taper of their steroid dose without a return of their GVHD
   AND
3. Documentation showing a baseline measure of severity that will be used to evaluate improvement (e.g., organ system staging for acute GVHD symptoms, GVHD grade based on MAGIC criteria, or presence of GVHD symptoms [skin, liver, or gut]) [DOCUMENTATION REQUIRED]
   AND
4. Documentation member has tried and failed or has a labeled contraindication to mycophenolate

D. CHRONIC GRAFT VERSUS HOST DISEASE:
1. Documentation of diagnosis of chronic graft versus host disease
AND
2. Documentation member has previously received at least one systemic therapy for GVHD (i.e., corticosteroids, mycophenolate, cyclosporine, tacrolimus)
AND
3. Documentation of baseline signs and symptoms (e.g., dry eyes, shortness of breath, rash, mouth sores, tingling sensation, muscle and joint pain, etc.) [DOCUMENTATION REQUIRED]

CONTINUATION OF THERAPY:

A. ALL INDICATIONS:
1. Documentation of one of the following [DOCUMENTATION REQUIRED]:
a) FOR POLYCYTHEMIA VERA: Documentation of a positive response to treatment with a reduction from pretreatment baseline in palpable spleen length or a reduction in spleen volume as measured by CT or MRI
OR
b) FOR MYELOFIBROSIS: Documentation of a positive response to treatment with a decrease in spleen size or improvements in other myelofibrosis symptoms (such as fatigue, bone pain, frequent infections, fever, night sweats, easy bruising/bleeding, etc.) or reduction in the Total Symptom Score from baseline as measured by the modified Myelofibrosis Symptom Assessment Form (MFSAF)
OR
c) FOR ACUTE GVHD: Score of 0 for GVHD grading [see Appendix] in all evaluable organs OR partial response based on symptoms [Skin: no rash or residual erythematous rash involving <25%of body surface, without bullae (residual faint erythema [redness of skin] and hyperpigmentation do not count), Liver: total serum bilirubin concentration <2 mg/dL, or <25% baseline at enrollment, Gut: tolerating food or enteral feeding, predominantly formed stools, no overt GI bleeding or abdominal cramping, no more than occasional nausea or vomiting] OR Improvement in 1 stage in ≥1 organ involved with GVHD symptoms without progression in others
OR
d) FOR CHRONIC GVHD: Member has documented improvement in signs/symptoms of chronic GVHD (e.g., dry eyes, shortness of breath, rash, mouth sores, tingling sensation, muscle and joint pain, etc.)
AND
2. Adherence to therapy at least 85% of the time as verified by the prescriber or member medication fill history OR adherence less than 85% of the time due to the need for surgery or treatment of an infection, causing temporary discontinuation, or held for toxicity

DURATION OF APPROVAL:

Initial authorization: 6 months, Continuation of Therapy: 12 months

PRESCRIBER REQUIREMENTS:

Prescribed by or in consultation with a hematologist, oncologist, or transplant specialist [If prescribed in consultation, consultation notes must be submitted with initial request and reauthorization requests]

AGE RESTRICTIONS:

Myelofibrosis, Polycythemia Vera: 18 years of age and older
Graft Versus Host Disease: 12 years of age and older

QUANTITY:

Acute Graft-versus-host disease: max dose of 10 mg twice daily
Chronic Graft-versus-host disease: max dose of 10 mg twice daily

Myelofibrosis: max dose of 25 mg twice daily
Polycythemia vera: max dose 25 mg twice daily
NOTE: Quantities approved should allow for dose adjustments for cytopenias and/or renal/hepatic impairment, while using the least number of tablets per dose.

PLACE OF ADMINISTRATION:
The recommendation is that oral medications in this policy will be for pharmacy benefit coverage and patient self-administered.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:
Oral

DRUG CLASS:
Janus Associated Kinase (JAK) Inhibitors

FDA-APPROVED USES:
Indicated for treatment of: intermediate or high-risk myelofibrosis, 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, steroid-refractory acute graft-versus-host disease in adult and pediatric patients 12 years and older, and chronic graft-versus-host disease after failure of one or two lines of systemic therapy in adult and pediatric patients 12 years and older

COMPENDIAL APPROVED OFF-LABELED USES:
Low risk, symptomatic Myelofibrosis (NCCN Myeloproliferative Neoplasms Version 1.2025 MF-1), Myeloid/ lymphoid neoplasms with eosinophilia and JAK2 rearrangement (NCCN Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions Version 2.2025 MLNE-8)

APPENDIX

APPENDIX:
2005 and 2014 National Institutes of Health Consensus chronic GVHD classification

Confidence Level	Pathologic Evidence	Clinician Assessment	Treatment for Acute GVHD	Comments
Confirmed	Unequivocal pathologic evidence of GVHD	GVHD is the etiology for symptoms	Not applicable	GVHD is clearly present even if other etiologies may coexist simultaneously.
Probable	Not required	GVHD most likely etiology for symptoms (as evidenced by treatment being provided)	Yes	GVHD is most likely present, but other etiologies may also explain the symptoms, and there is insufficient evidence to make a confirmed diagnosis.
Possible	Not required	GVHD in differential diagnosis (but no treatment is being provided)	No	GVHD may be present, but other etiologies are favored to the degree that GVHD treatment is not initiated.
Negative	Unequivocal evidence of a diagnosis other than GVHD (eg, drug rash)	GVHD is not considered as an explanation for the symptoms	No *and* the symptoms resolve without GVHD treatment	A "negative" biopsy (eg, normal skin) is not unequivocal evidence of a diagnosis other than GVHD.

Stage	Skin (Active Erythema Only)	Liver (Bilirubin)	Upper GI	Lower GI (stool output/day)
0	No active (erythematous) GVHD rash	<2 mg/dL	No or intermittent nausea, vomiting, or anorexia	Adult: <500 mL/day or <3 episodes/day Child: <10 mL/kg/day or <4 episodes/day
1	Maculopapular rash <25% BSA	2-3 mg/dL	Persistent nausea, vomiting or anorexia	Adult: 500-999 mL/day or 3-4 episodes/day Child: 10-19.9 mL/kg/day or 4-6 episodes/day
2	Maculopapular rash 25-50% BSA	3.1-6 mg/dL		Adult: 1000-1500 mL/day or 5-7 episodes/day Child: 20-30 mL/kg/day or 7-10 episodes/day
3	Maculopapular rash >50% BSA	6.1-15 mg/dL		Adult: >1500 mL/day or >7 episodes/day Child: >30 mL/kg/day or >10 episodes/day
4	Generalized erythroderma (>50% BSA) *plus* bullous formation and desquamation >5% BSA	>15 mg/dL		Severe abdominal pain with or without ileus or grossly bloody stool (regardless of stool volume).

Overall clinical grade (based on most severe target organ involvement):

Grade 0: No stage 1-4 of any organ.

Grade I: Stage 1-2 skin without liver, upper GI, or lower GI involvement.

Grade II: Stage 3 rash and/or stage 1 liver and/or stage 1 upper GI and/or stage 1 lower GI.

Grade III: Stage 2-3 liver and/or stage 2-3 lower GI, with stage 0-3 skin and/or stage 0-1 upper GI.

Grade IV: Stage 4 skin, liver, or lower GI involvement, with stage 0-1 upper GI.

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
Comprehensive Network (NCCN) also recommends Jakafi for the treatment of patients with polycythemia vera who have had an inadequate response to interferon therapy.

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of Jakafi (ruxolitinib) are considered experimental/investigational and therefore, will follow Molina's Off- Label policy. Contraindications to Jakafi (ruxolitinib) include: No labeled contraindications.

Exclusions/Discontinuation:

Jakafi should be used as monotherapy for the treatment of myelofibrosis (excludes medically necessary supportive agents.
Jakafi should not be used as combination therapy for the treatment of acute GVHD.
Jakafi should not be used as combination therapy for the treatment of chronic GVHD.
Discontinue Jakafi if there is no spleen size reduction or symptom improvement after 6 months of therapy for treatment of myelofibrosis.

OTHER SPECIAL CONSIDERATIONS:
The recommended starting dose of Jakafi is based on platelet count. Doses may be titrated based on safety and efficacy. FDA label has recommended dose modification for adverse drug reactions.

CODING/BILLING INFORMATION

CODING DISCLAIMER. *Codes listed in this policy are for reference purposes only and may not be all-inclusive or applicable for every state or line of business. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry-standard coding practices for all submissions. Molina has the right to reject/deny the claim and recover claim payment(s) if it is determined it is not billed appropriately or not a covered benefit. Molina reserves the right to revise this policy as needed.*

HCPCS CODE	DESCRIPTION
N/A	N/A

AVAILABLE DOSAGE FORMS:
Jakafi TABS 5MG, 10MG, 15MG, 20MG, 25MG

REFERENCES

1. Jakafi (ruxolitinib) tablets, for oral use [prescribing information]. Wilmington, DE: Incyte Corporation; January 2023.
2. Khoury HJ, Langston AA, Kota VK, et al. Ruxolitinib: A steroid sparing agent in chronic graft- versus-host disease. [published ahead of print January 24, 2018]. Bone Marrow Transplant. 2018. Doi: 10.1038/s41409-017-0081-5
3. Mesa RA, Gotlib J, Gupta V, et al. Effect of ruxolitinib therapy on myelofibrosis-related symptoms and other patient-reported outcomes in COMFORT-I: a randomized, double-blind, placebo- controlled trial. J Clin Oncol. 2013;31(10):1285-1292.
4. Vannucchi AM, Kiladjian JJ, Griesshammer M, et al. Ruxolitinib versus standard therapy for the treatment of polycythemia vera. N Engl J Med. 2015;372(5):426-435.
5. Verstovsek S, Mesa RA, Gotlib J, et al, “A Double Blind, Placebo-Controlled Trial of Ruxolitinib for Myelofibrosis,” N Engl J Med, 2012, 366(9):799-807.
6. Zeiser R, Burchert A, Lengerke C, et al. Ruxolitinib in corticosteroid-refractory graft-versus- host disease after allogeneic stem cell transplantation: a multicenter survey. Leukemia. 2015;29(10):2062-2068. Doi: 10.1038/leu.2015.212
7. Gerds AT, Dao KH. Polycythemia vera management and challenges in the community health setting. Oncology. 2017;92(4):179-189. Doi: 10.1159/000454953
8. Harris, A., Young, R., Devine, S., Hogan, W., Ayuk, F., & Bunworasate, U. et al. (2016). International, Multicenter Standardization of Acute Graft-versus-Host Disease Clinical Data Collection: A Report from the Mount Sinai Acute GVHD International Consortium. Biology Of Blood And Marrow Transplantation,

22(1), 4-10. Doi: 10.1016/j.bbmt.2015.09.001
9. National Comprehensive Cancer Network. 2022. Hematopoietic Cell Transplantation (HCT) (Version 1.2022). [online] Available at: <https://www.nccn.org/professionals/physician_gls/pdf/hct.pdf > [Accessed 9 August 2022].
10. National Comprehensive Cancer Network. 2023. Myeloproliferative Neoplasms (Version 3.2022). [online] Available at: < mpn.pdf (nccn.org) > [Accessed 2 April 2023].
11. National Comprehensive Cancer Network. 2024. Myeloproliferative Neoplasms (Version 1.2024). [online] Available at: < mpn.pdf (nccn.org) > [Accessed 10 April 2024].
12. National Comprehensive Cancer Network. 2025. Myeloproliferative Neoplasms (Version 1.2025). [online] Available at: < mpn.pdf (nccn.org) > [Accessed 8 April 2025].

SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Compendial Approved Off-Labeled Uses Contraindications/Exclusions/Discontinuations Other Special Considerations References	Q2 2025
REVISION- Notable revisions: Required Medical Information Continuation of Therapy References	Q2 2024
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Quantity Drug Class Compendial Approved Off-Labeled Uses References	Q2 2023
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Quantity FDA-Approved Uses Contraindications/Exclusions/Discontinuation References	Q4 2022
Q2 2022 Established tracking in new format	Historical changes on file