UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1052-14
Program	Prior Authorization/Notification
Medication	Jakafi® (ruxolitinib)
P&T Approval Date	1/2012, 8/2012, 7/2013, 5/2014, 5/2015, 5/2016, 5/2017, 3/2018, 3/2019, 3/2020, 3/2021, 11/2021, 11/2022, 11/2023, 11/2024, 11/2025
Effective Date	2/1/2026

A. Background:

Jakafi® (ruxolitinib) is a kinase inhibitor indicated for treatment of patients with intermediate or high-risk myelofibrosis, including primary myelofibrosis (PMF), post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis in adults. It is also indicated in adult patients with polycythemia vera who have had an inadequate response to or are intolerant of hydroxyurea. It is also indicated for the treatment of 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.

The National Cancer Comprehensive Network (NCCN) also recommends Jakafi for the treatment of polycythemia vera, essential thrombocythemia, accelerated/blast phase myeloproliferative neoplasm, lymphoid, myeloid/lymphoid neoplasms with eosinophilia and JAK2 rearrangement, myelodysplastic syndromes, pediatric acute lymphoblastic leukemia, T-Cell Lymphomas, and management of CAR-T-cell and immunotherapy-related toxicities.

Coverage Information:
Members will be required to meet the criteria below for coverage. For members under the age of 19 years, the prescription will automatically process without a coverage review.

Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances. Some states also mandate usage of other Compendium references. Where such mandates apply, they supersede language in the benefit document or in the notification criteria.

2. Coverage Criteria[a]:

A. <u>Patients less than 19 years of age</u>

1. **Jakafi** will be approved based on the following criterion:

   a. Patient is less than 19 years of age

   Authorization will be issued for 12 months.

B. <u>Myelofibrosis</u>

1. **<u>Initial Authorization</u>**

a. **Jakafi** will be approved based on **one** of the following:

(1) Diagnosis of **one** of the following:

(a) Symptomatic lower-risk myelofibrosis

-OR-

(b) Intermediate or higher-risk myelofibrosis

-OR-

(c) Post-polycythemia vera myelofibrosis

-OR-

(d) Post-essential thrombocythemia myelofibrosis

-OR-

(2) **All** of the following:

(a) Diagnosis of myelofibrosis-associated anemia

-AND-

(b) Presence of symptomatic splenomegaly and/or constitutional symptoms

-AND-

(c) Given in combination with **one** of the following:

i. Reblozyl (luspatercept)

ii. Erythropoetin stimulating agent (ESA) if serum EPO < 500 mU/mL

iii. Danazol

Authorization will be issued for 6 months.

2. **Reauthorization**

a. **Jakafi** will be approved based on **one** of the following criteria:

(1) Documentation that patient has evidence of symptom improvement or reduction in spleen volume while on Jakafi

Authorization will be issued for 6 months.

-OR-

(2) Documentation does not provide evidence of symptom improvement or reduction in spleen volume while on Jakafi, allow for dose titration with discontinuation of therapy

Authorization will be issued for 2 months.

C. Polycythemia vera

1. **Initial Authorization**

a. **Jakafi** will be approved based on **both** of the following:

(1) Diagnosis of polycythemia vera

-AND-

(2) History of failure, inadequate response, contraindication, or intolerance to **one** of the following:

(a) Hydroxyurea

(b) Interferon therapy [e.g., Besremi (ropeginterferon alfa-2b), Intron A (interferon alfa-2b), Pegasys (peginterferon alfa-2a)]

Authorization will be issued for 6 months.

2. **Reauthorization**

a. **Jakafi** will be approved based on **one** of the following criteria:

(1) Documentation that patient has evidence of symptom improvement or reduction in spleen volume while on Jakafi

Authorization will be issued for 6 months.

-OR-

(2) Documentation does not provide evidence of symptom improvement or reduction in spleen volume while on Jakafi, allow for dose titration with discontinuation of therapy

Authorization will be issued for 2 months.

D. Essential thrombocythemia

1. **Initial Authorization**

   a. **Jakafi** will be approved based on **both** of the following:

      (1) Diagnosis of essential thrombocythemia

      -AND-

      (2) Inadequate response or loss of response to **one** of the following:

         (a) Hydroxyurea

         (b) Pegasys (peginterferon alfa-2a)

         (c) Agrylin (Anagrelide)

   Authorization will be issued for 6 months.

2. **Reauthorization**

   a. **Jakafi** will be approved based on **one** of the following criteria:
      (1) Documentation that patient has evidence of symptom improvement or reduction in spleen volume while on Jakafi

   Authorization will be issued for 6 months.

   -OR-

      (2) Documentation does not provide evidence of symptom improvement or reduction in spleen volume while on Jakafi, allow for dose titration with discontinuation of therapy

   Authorization will be issued for 2 months.

E. Graft versus host disease (GVHD)

1. **Initial Authorization**

   a. **Jakafi** will be approved based on **one** of the following:

      (1) **Both** of the following:

         (a) Diagnosis of acute GVHD

         (b) Disease is steroid refractory

      -OR-

      (2) **Both** of the following:

(a) Diagnosis of chronic GVHD

(b) Failure of one or two lines of systemic therapy

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Jakafi** will be approved based on the following criterion:

(1) Documentation of symptom improvement while on Jakafi

Authorization will be issued for 12 months.

F. Myeloid/Lymphoid Neoplasms

1. **Initial Authorization**

a. **Jakafi** will be approved based on **both** of the following:

(1) Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

-AND-

(2) Patient has a JAK2 rearrangement

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Jakafi** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on **Jakafi** therapy.

Authorization will be issued for 12 months.

G. Myelodysplastic Syndromes

1. **Initial Authorization**

a. **Jakafi** will be approved based on **one** of the following:

(1) **Both** of the following:

(a) Diagnosis of chronic myelomonocytic leukemia (CMML)-2

(b) Use in combination with a hypomethylating agent (e.g., azacitidine, decitabine)

-OR-

(2) **Both** of the following:

(a) Diagnosis of myelodysplastic/myeloproliferative neoplasm (MDS/MPN) with neutrophilia
(b) Disease is positive for CSF3R or JAK2 mutation

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Jakafi** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on **Jakafi** therapy.

Authorization will be issued for 12 months.

H. Myeloproliferative Neoplasms

1. **Initial Authorization**

a. **Jakafi** will be approved based on **both** of the following:

(1) Diagnosis of accelerated/blast phase myeloproliferative neoplasm

-AND-

(2) Used for splenomegaly or other disease-related symptoms

Authorization will be issued for 6 months.

2. **Reauthorization**

a. **Jakafi** will be approved based on **one** of the following criteria:

(1) Documentation that patient has evidence of symptom improvement or reduction in spleen volume while on Jakafi

Authorization will be issued for 6 months.

-OR-

(2) Documentation does not provide evidence of symptom improvement or reduction in spleen volume while on Jakafi, allow for dose titration with discontinuation of therapy

Authorization will be issued for 2 months.

I. Pediatric Acute Lymphoblastic Leukemia

1. **Authorization**

a. **Jakafi** will be approved based on the following criterion:

(1) Diagnosis of pediatric acute lymphoblastic leukemia

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Jakafi** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on **Jakafi** therapy.

Authorization will be issued for 12 months.

J. Immunotherapy-Related Toxicities

1. **Authorization**

a. **Jakafi** will be approved based on **one** of the following criteria:

(1) **Both** of the following:

(a) Diagnosis of CAR-T induced G4 cytokine release syndrome

(b) Disease is refractory to high-dose corticosteroids and anti-IL-6 therapy [e.g., Actemra (tocilizumab)]

-OR-

(2) **Both** of the following:

(a) Diagnosis of immunotherapy-related toxicities

(b) **One** of the following:

i. Used in combination with Orencia (abatacept) for the management of concomitant myositis and myocarditis

ii. Used as additional therapy for hemophagocytic lymphohistiocytosis-like syndrome if no response to corticosteroids after 5 days

Authorization will be issued for 12 months.

K. T-Cell Lymphomas

1. **Initial Authorization**

a. **Jakafi** will be approved based on **one** of the following criteria:

(1) **Both** of the following:

(a) Diagnosis of peripheral T-cell lymphoma

-AND-

(b) Used as initial palliative intent therapy or second-line and subsequent therapy for relapsed/refractory disease

-OR-

(2) **Both** of the following:

(a) **One** of the following diagnoses:

i. T-cell large granular lymphocytic leukemia
ii. T-cell prolymphocytic leukemia
iii. Breast implant-associated anaplastic large cell lymphoma (ALCL)

-AND-

(b) Used as second-line or subsequent therapy

-OR-

(3) **Both** of the following:

(a) Diagnosis of hepatosplenic T-cell lymphoma

-AND-

(b) Used for refractory disease after two first-line therapy regimens

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Jakafi** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on **Jakafi** therapy.

Authorization will be issued for 12 months.

L. NCCN Recommended Regimens

The drug has been recognized for treatment of the cancer indication by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Jakafi [package insert]. Wilmington, DE: Incyte Corporation; June 2025.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed September 29, 2025

Program	Prior Authorization/Notification - Jakafi® (ruxolitinib)
Change Control	
5/2014	Annual review with no change to coverage.
5/2015	Added clinical criteria for polycythemia vera. Updated references.
5/2016	Annual review. Added 6 month initial authorization time frame to Myeofibrosis. Updated references.
5/2017	Annual review. Changed member to patient in coverage criteria. Changed word criterion to criteria in reauthorization of coverage criteria.
3/2018	Annual review. Added off label criteria for management of steroid refractory GVHD based on consultant feedback and review of emerging evidence. Updated references.
3/2019	Annual review. Updated criteria for polycythemia vera to align with NCCN recommendation. Updated references.

3/2020	Annual review. Updated background, added general NCCN recommendations for use criteria. Updated reference.
3/2021	Annual review. Coverage criteria added for Myeloid/Lymphoid Neoplasms and Myelodysplastic Syndromes per NCCN recommendations. Reference updated.
11/2021	Updated background to include new indication for treatment of chronic GVHD. Added coverage criteria for pediatric acute lymphoblastic leukemia and CAR-T cell related toxicities per NCCN recommendations. References updated.
11/2022	Annual review. Updated background per prescribing information, added state mandate, and updated references.
11/2023	Annual review. Added criteria for T-cell lymphomas and essential thrombocythemia per NCCN recommendations. Updated criteria for pediatric ALL. Updated criteria for GVHD per FDA label. Updated background. Updated references.
11/2024	Annual review. Updated background per NCCN guidelines. Updated criteria for myelofibrosis, polycythemia vera, graft versus host disease, myeloid/lymphoid neoplasms, myelodysplastic syndromes, pediatric acute lymphoblastic leukemia, immunotherapy-related toxicities, and T-cell lymphomas. Added new section for myeloproliferative neoplasms. Updated duration of approval for additional NCCN recommended regimens.
11/2025	Annual review. Updated coverage criteria for myelofibrosis, polycythemia vera, immunotherapy-related toxicities, and T-cell lymphoma based on NCCN recommendations. Added reauthorization criteria for pediatric acute lymphocytic leukemia. Updated references.