

**Applicable Drugs:** Jakafi (ruxolitinib)

**Preferred:** N/A

**Non-preferred:** N/A

**Date of Origin:** 2/1/2013

**Date Last Reviewed / Revised:** 3/14/2026

## **PRIOR AUTHORIZATION CRITERIA**

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

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

### FDA-Approved Indication(s)

- A. Myelofibrosis, including but not limited to primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis
  - i. Minimum age requirement: 18 years old.
- B. Polycythemia vera
  - i. Documented inadequate response, intolerance, or contraindication to hydroxyurea.
  - ii. Minimum age requirement: 18 years old.
- C. Acute graft-versus-host disease
  - i. Documentation trial and failure of steroids.
  - ii. Minimum age requirement: 12 years old.
- D. Chronic graft-versus-host disease
  - i. Documented failure of at least one line of systemic therapy.
  - ii. Minimum age requirement: 12 years old.

### Other Uses with Supportive Evidence

- E. Essential thrombocythemia
- F. Accelerated or blast phase myeloproliferative neoplasm
- G. Immunotherapy-related concomitant myositis
- H. Myeloid/lymphoid neoplasms
- I. Chronic myelomonocytic leukemia (CMML)-2
- J. Myelodysplastic/myeloproliferative neoplasm (MDS/MPN) or atypical chronic myeloid leukemia (aCMP)
- K. Pediatric acute lymphoblastic leukemia

- I. T-cell lymphocytic leukemia (T-LGLL)
- II. Treatment must be prescribed by or in consultation with an oncologist or a hematologist.
- III. Request is for a medication with the appropriate FDA labeling, or its use is supported by current National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1 or 2A.
- IV. 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

- N/A

#### OTHER CRITERIA

- N/A

#### QUANTITY / DAYS SUPPLY RESTRICTIONS

- Quantities of up to 60 tablets per 30 days.

#### APPROVAL LENGTH

- **Authorization:** 1 year.
- **Re-Authorization:** 1 year. 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. Jakafi. Prescribing Information. Incyte; January 2023. Available at: <http://www.jakafi.com/pdf/prescribing-information.pdf>.
2. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Myelodysplastic Syndromes. Version 3.2026. Updated January 12, 2026. Accessed March 3, 2026. [https://www.nccn.org/professionals/physician\\_gls/pdf/mds.pdf](https://www.nccn.org/professionals/physician_gls/pdf/mds.pdf).
3. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Myeloproliferative Neoplasms. Version 1.2026. Updated January 22, 2026. Accessed March 3, 2026. [https://www.nccn.org/professionals/physician\\_gls/pdf/mpn.pdf](https://www.nccn.org/professionals/physician_gls/pdf/mpn.pdf).

4. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Hematopoietic Cell Transplantation. Version 3.2025. Updated September 24, 2025. Accessed March 3, 2026. [https://www.nccn.org/professionals/physician\\_gls/pdf/hct.pdf](https://www.nccn.org/professionals/physician_gls/pdf/hct.pdf).
5. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Management of Immune Checkpoint Inhibitor-Related Toxicities. Version 1.2026. Updated October 23, 2025. Accessed March 3, 2026. [https://www.nccn.org/professionals/physician\\_gls/pdf/ici\\_tox.pdf](https://www.nccn.org/professionals/physician_gls/pdf/ici_tox.pdf)
6. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions. Version 1.2026. Updated October 3, 2025. Accessed March 3, 2026. [www.nccn.org/professionals/physician\\_gls/pdf/mlne.pdf](http://www.nccn.org/professionals/physician_gls/pdf/mlne.pdf)
7. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Pediatric Acute Lymphoblastic Leukemia. Version 1.2026. Updated August 11, 2025. Accessed March 3, 2026. [www.nccn.org/professionals/physician\\_gls/pdf/ped\\_all.pdf](http://www.nccn.org/professionals/physician_gls/pdf/ped_all.pdf)
8. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. T-Cell Lymphomas. Version 2.2026. Updated February 13, 2026. Accessed March 3, 2026. [www.nccn.org/professionals/physician\\_gls/pdf/t-cell.pdf](http://www.nccn.org/professionals/physician_gls/pdf/t-cell.pdf)

**DISCLAIMER:** Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer 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.