RXADVANCE
2 Park Central Drive
Southborough, MA 01772

Clinical Policy Title:	fedratinib
Policy Number:	RxA.173
Drug(s) Applied:	Inrebic®
Original Policy Date:	02/07/2020
Last Review Date:	09/14/2020
Line of Business Policy Applies to:	All lines of business

Background

Fedratinib (Inrebic®) is a kinase inhibitor. Inrebic® is indicated for the treatment of adult patients with intermediate-2 or high-risk primary or secondary (post-polycythemia vera (post-PV) or post-essential thrombocythemia (post-ET)) myelofibrosis (MF).

Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
fedratinib (Inrebic®)	MF	400 mg PO once daily	400 mg/day

Dosage Forms

- Capsule: 100 mg

Clinical Policy

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

I. Initial Approval Criteria

A. Myelofibrosis (must meet all)**:**

1. Diagnosis of intermediate-2 or high-risk primary MF, post-PV MF, or post-ET MF;
2. Prescribed by or in consultation with a hematologist or oncologist;
3. Age ≥ 18 years;
4. Documentation of a recent (within the last 30 days) thiamine level of ≥ 70 nmol/L (3 mcg/dL);
5. Documentation of a recent (within the last 30 days) platelet count of ≥ 50,000/mcL;
6. Request meets one of the following (a or b): *
   a. Dose does not exceed 400 mg (4 capsules) per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

**Prescribed regimen must be FDA-approved or recommended by NCCN*
Approval Duration
Commercial: 6 months
Medicaid: 6 months

II. Continued Therapy Approval

A. Myelofibrosis (must meet all)**:**

1. Currently receiving medication that has been authorized by RxAdvance , or documentation supports that member is currently receiving Inrebic® for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 400 mg (4 capsules) per day;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*
Approval Duration
Commercial: 12 months
Medicaid: 12 months

III. Appendices

APPENDIX A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
MF: Myelofibrosis
NCCN: National Comprehensive Cancer Network
Post-ET: Post-essential thrombocythemia
Post-PV: Post-polycythemia vera

APPENDIX B: Therapeutic Alternatives
Not applicable

APPENDIX C: Contraindications/Boxed Warnings
- Contraindication(s):
  - None
- Boxed Warning(s):
  - Serious and fatal encephalopathy, including Wernicke's

APPENDIX D: General Information
- NCCN recommendations for the initial treatment of intermediate-2 or high-risk MF include the use of Jakafi® as a category 2A recommendation and the use of Inrebic® as a category 2B recommendation. Inrebic® also has a category 2A recommendation for use after failure or intolerance to Jakafi.
- The Inrebic® Prescribing Information and NCCN guidelines for myeloproliferative neoplasms recommend a baseline platelet count of ≥ 50,000/mcL before initiation of Inrebic®. The Jakafi Prescribing Information also recommends the same baseline platelet count for Jakafi, but NCCN guidelines include support for use of Jakafi for low- or intermediate-1 risk MF without regard to baseline platelet counts.
- Examples of positive response to therapy for myelofibrosis include: reduction in spleen size or improvement in symptoms such as pruritus, fatigue, night sweats, bone pain since initiation of therapy.

References

1. Inrebic® Prescribing Information. Summit, NJ: Celgene Corporation. August 2019. Available at http://www.inrebicpro.com. Accessed June 23, 2020.
2. Myeloproliferative neoplasms (Version 3.2019). National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed June 24, 2020 .
3. Pardanani A, Harrison C, Cortes JE, et al. Safety and Efficacy of Fedratinib in Patients With Primary or Secondary Myelofibrosis – A Randomized Clinical Trial. JAMA Oncol. 2015;1(5): 643-51. Accessed June 24, 2020.
4. Fedratinib. Micromedex Solutions. Truven Health Analytics Inc. Ann Arbor, MI. Available at https://www.micromedexsolutions.com. Accessed June 24, 2020
5. Clinical Pharmacology [database online] powered by ClinicalKey. Tampa, FL: Elsevier, 2020. Accessed with subscription at: http://www.clinicalkey.com. Updated January 14, 2020. Accessed June 24, 2020.
6. Fedratinib, Lexi-Drug. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Accessed with subscription at: http://online.lexi.com. Accessed June 23, 2020.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	02/07/2020
Policy was reviewed: 1. Policy title table was updated: Clinical Policy Title was updated to "fedratinib". Drug(s) Applied was updated to "Inrebic®". Line of Business Policy Applies to was updated to "All lines of business"3. Clinical policy was updated: Approval duration was updated for both Initial and Continued Approval Criteria; Continued Approval was rephrased to "Currently receiving medication that has been authorized by RxAdvance… ". 4. References were updated.	06/24/2020	09/14/2020