UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Inrebic

Program	Prior Authorization
Medications	Inrebic® (fedratinib)
Markets in Scope	Arizona, California, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania- CHIP, Rhode Island, South Carolina
Issue Date	10/2019
Pharmacy and Therapeutics Approval Date	10/2020
Effective Date	12/2020

1. Background:

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

The National Cancer Comprehensive Network (NCCN) also recommends Inrebic for the treatment of myeloid/lymphoid neoplasms with eosinophilia and JAK2 rearrangement.

2. Coverage Criteria:

A. Myelofibrosis

1. **Initial Authorization**

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

      (1) Primary myelofibrosis

      -OR-

      (2) Post-polycythemia vera myelofibrosis

      -OR-

      (3) Post-essential thrombocythemia myelofibrosis

   Authorization will be issued for 12 months.

2. **Reauthorization**

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

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

Authorization will be issued for 12 months.

C. Myeloid/Lymphoid Neoplasms

1. **Initial Authorization**

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

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

Authorization will be issued for 12 months.

B. NCCN Recommended Regimens

1. **Initial Authorization**

a. **Inrebic** will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium.

Authorization will be issued for 12 months.

2. **Reauthorization**

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

(1) Documentation of positive clinical response to Inrebic therapy.

Authorization will be issued for 12 months.

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. Inrebic [package insert]. Summit, NJ: Celgene Corporation; August 2019.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at https://www.nccn.org/professionals/drug_compendium/content/ Accessed August 28, 2020

Program	Prior Authorization Inrebic
Change Control	
10/2019	New program.
10/2020	Annual review. Updated background and coverage criteria to include NCCN recommended use in myeloid/lymphoid neoplasms. Updated references. Added Additional Clinical Rules section.