Clinical Policy: Fedratinib (Inrebic)

Reference Number: ERX.SPA.354
Effective Date: 12.01.19
Last Review Date: 11.21
Line of Business: Commercial, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Fedratinib (Inrebic®) is a kinase inhibitor.

FDA Approved Indication(s)
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).

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

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Inrebic is **medically necessary** when the following criteria are met:

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:
Medicaid – 6 months
Commercial – Length of Benefit

B. Other diagnoses/indications

1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

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

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions, 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:
Medicaid – 12 months
Commercial – Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off-label use policy – ERX.PA.01 or evidence of coverage documents.

IV. Appendices/General Information

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 reported
- 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 in myelofibrosis include reduction in spleen size or improvement in symptoms such as pruritus, fatigue, night sweats, bone pain since initiation of therapy.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MF	400 mg PO QD	400 mg/day

VI. Product Availability

Capsule: 100 mg

VII. References

1. Inrebic Prescribing Information. Summit, NJ: Celgene Corporation; August 2019. Available at http://www.inrebicpro.com. Accessed June 22, 2021.
2. Myeloproliferative neoplasms (Version 1.2021). National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed June 22, 2021.
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.
4. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed June 22, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	10.01.19	11.19
4Q 2020 annual review: no significant changes; references reviewed and updated.	07.15.20	11.20
4Q 2021 annual review: no significant changes; references reviewed and updated.	06.22.21	11.21

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members.