Original Effective Date: 04/28/2022
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Last P&T Approval/Version: 04/24/2024
Next Review Due By: 04/2025
Policy Number: C23019-A

Vonjo (pacritinib)

PRODUCTS AFFECTED

Vonjo (pacritinib)

COVERAGE POLICY

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:
Cytopenic myelofibrosis

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by-case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

A. MYELOFIBROSIS:
   1. Member has clinically documented primary myelofibrosis, post-polycythemia vera myelofibrosis, or post- essential thrombocythemia myelofibrosis
      AND

2. Documentation member has intermediate or high-risk disease as defined by possessing TWO or more of the following criteria: a) Age > 65, b) documented hemoglobin < 10 g/dL, c) documented WBC >25 x 10^9/L, d) circulating blasts ≥1% OR e) presence of constitutional symptoms (weight loss >10% from baseline or unexplained fever or excessive sweats persisting for more than 1 month)
   AND
3. Documentation of baseline complete blood count (CBC) with platelet count below 50 x 10^9/L
   AND
4. Documentation member has splenomegaly based on palpable spleen length or spleen volume [DOCUMENTATION REQUIRED]
   AND
5. Prescriber attests that member is ineligible for allogeneic hematopoietic cell transplantation (HCT)
   AND
6. Prescriber attests baseline complete blood count (including white blood cell count differential and platelet count), coagulation testing (prothrombin time, partial thromboplastin time, thrombin time, and international normalized ratio), and electrocardiogram (ECG) will be performed prior to starting Vonjo and monitoring will be done as clinically indicated while the member is on treatment
   AND
7. Documentation member is not currently taking a janus kinase inhibitor therapy or will taper or discontinue prior to starting Vonjo
   AND
8. Prescriber attests to (or the clinical reviewer has found that) the member not having any FDA labeled contraindications that haven't been addressed by the prescriber within the documentation submitted for review. [Contraindications to Vonjo (pacritinib) include: Concomitant use of strong or moderate CYP3A4 inhibitors or inducers, avoid use in patients with active bleeding, avoid use in patients with baseline QTc >480 msec, delay starting therapy until active serious infection have resolved, avoid concomitant use of sensitive substrates of P- gp, BCRP, OCTI, avoid use In patients with moderate (Child-Pugh B) and severe (Child-Pugh C) hepatic impairment, avoid use in patients with eGFR <30 ml/min]

CONTINUATION OF THERAPY:

A. MYELOFIBROSIS:
   1. Documentation member has not had a splenectomy
      AND
   2. Documentation of a positive response to treatment with a reduction in spleen volume from pretreatment baseline as measured by CT or MRI [DOCUMENTATION REQUIRED]
      AND
   3. Adherence to therapy at least 85% of the time as verified by the prescriber or member's medication fill history OR adherence less than 85% of the time due to the need for surgery or treatment of an infection, causing temporary discontinuation
      AND
   4. Prescriber attests complete blood count (including white blood cell count differential and platelet count), coagulation testing (prothrombin time, partial thromboplastin time, thrombin time, and international normalized ratio), and electrocardiogram (ECG) will be performed and monitored as clinically indicated while the member is on treatment
      AND
   5. Prescriber attests that member's medications have been reviewed for interacting or contraindicated agents and none have been found or the member will discontinue the concurrent interacting medication and be monitored
      AND
   6. Prescriber attests to using labeled dose modification when necessary for adverse drug reactions

DURATION OF APPROVAL:
Initial authorization: 6 months, Continuation of Therapy: 12 months

PRESCRIBER REQUIREMENTS:
Prescribed by or in consultation with a hematologist or oncologist, or transplant specialist. [If prescribed in consultation, consultation notes must be submitted with initial request and reauthorization requests]

AGE RESTRICTIONS:
18 years of age and older

QUANTITY:
200mg orally twice daily

PLACE OF ADMINISTRATION:
The recommendation is that oral medications in this policy will be for pharmacy benefit coverage and patient self-administered.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:
Oral

DRUG CLASS:
Janus Associated Kinase (JAK) Inhibitors

FDA-APPROVED USES:
Indicated for the treatment of adults with intermediate or high-risk primary or secondary (post- polycythemia vera or post-essential thrombocythemia) myelofibrosis with a platelet count below 50 x 10^9/L.

This indication is approved under accelerated approval based on spleen volume reduction. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

COMPENDIAL APPROVED OFF-LABELED USES:
Low risk, symptomatic Myelofibrosis (NCCN Myeloproliferative Neoplasms Version 1.2024 MF-1)

APPENDIX

APPENDIX:
None

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
Myelofibrosis (MF) is a type of myeloproliferative neoplasm (MPN). Symptoms of MPN often include constitutional symptoms, fatigue, pruritis, weight loss, symptoms from splenomegaly, and variable lab abnormalities including erythrocytosis, thrombocytosis, and leukocytosis. The mutations most likely involved in patients with MPN are JAK2, CALR, and MPL mutations.

Pacritinib is an oral kinase inhibitor with activity against wild-type Janus associated kinase 2 (JAK2) mutant $JAK2^{V617F}$, and FMS-like tyrosine kinase 3 (FLT3) which both contribute to signaling of several cytokines and growth factors that are important for hematopoiesis and immune function.
Myelofibrosis is often associated with dysregulated JAK2 signaling. Pacritinib has higher affinity for JAK2

compared to JAK3 and TYK2. At clinically relevant concentrations, if does not have affinity for JAK1 thereby causing less myelosuppression.

The accelerated approval of pacritinib for MF is based on results from the Phase 3 PERSIST-2 trial where 29% of patients with intermediate- or high-risk MF with splenomegaly and platelets below 50 x 10^9/L had a 35% reduction in spleen volume compared to 3% of patients receiving best available therapy. There was no statistically significant difference in overall survival between treatment arms in the study. The most commonly reported nonhematological adverse events (≥15%) were gastrointestinal, fatigue, peripheral edema, and dizziness. The majority of common nonhematologic adverse events were grade 1 or 2 in severity. Diarrhea was the most frequently observed adverse event (53%) and most often occurred in weeks 1 to 8. The most common adverse events leading to discontinuation were thrombocytopenia (pacritinib once daily [not approved] 4%), and anemia (pacritinib twice daily 3%). The rate of study death was lowest with pacritinib twice daily (6%) compared to BAT (9%) and pacritinib once daily [not approved] (14%).

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of Vonjo (pacritinib) are considered experimental/investigational and therefore, will follow Molina's Off- Label policy. Contraindications to Vonjo (pacritinib) include: Concomitant use of strong or moderate CYP3A4 inhibitors or inducers, avoid use in patients with active bleeding, avoid use in patients with baseline QTc >480 msec, delay starting therapy until active serious infection have resolved, avoid sensitive substrates of P-gp, BCRP, OCTI, avoid use in patients with moderate (Child-Pugh B) and severe (Child-Pugh C) hepatic impairment, avoid use in patients with eGFR <30 ml/min.

OTHER SPECIAL CONSIDERATIONS:
Dose modification should be used for diarrhea, thrombocytopenia, hemorrhage, and prolonged QT interval. Dose levels are: 200mg twice daily (initial starting dose), 100mg twice daily (first dose reduction), 100mg once daily (second dose reduction). Vonjo should be discontinued in patients unable to tolerate a dose of 100mg once daily.

CODING/BILLING INFORMATION

Note: 1) This list of codes may not be all-inclusive. 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

HCPCS CODE	DESCRIPTION
NA	

AVAILABLE DOSAGE FORMS:
Vonjo CAPS 100MG

REFERENCES

1. Vonjo (pacritinib) [prescribing information]. Seattle, WA: CTI BioPharma Corp.; August 2023.
2. Mesa, R., Vannucchi, A., Mead, A., Egyed, M., Szoke, A., Suvorov, A., Jakucs, J., Perkins, A., Prasad, R., Mayer, J., Demeter, J., Ganly, P., Singer, J., Zhou, H., Dean, J., te Boekhorst, P., Nangalia, J., Kiladjian, J. and Harrison, C., 2017. Pacritinib versus best available therapy for the treatment of myelofibrosis irrespective of baseline cytopenias (PERSIST-1): an international, 9andomized, phase 3 trial. The Lancet Haematology, 4(5), pp.e225-e236.

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4. Gerds, A., Savona, M., Scott, B., Talpaz, M., Egyed, M., Harrison, C., Yacoub, A., Vannucchi, A., Mead, A., Kiladjian, J., O'Sullivan, J., García-Gutiérrez, V., Bose, P., Rampal, R., Miller, C., Palmer, J., Oh, S., Buckley, S., Mould, D., Ito, K., Tyavanagimatt, S., Smith, J., Roman-Torres, K., Devineni, S., Craig, A. and Mascarenhas, J., 2020. Determining the recommended dose of pacritinib: results from the PAC203 dose-finding trial in advanced myelofibrosis. Blood Advances, 4(22), pp.5825-5835.
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7. National Comprehensive Cancer Network. 2024. Myeloproliferative Neoplasms (Version 1.2024). [online] Available at: < mpn.pdf (nccn.org) > [Accessed 10 April 2024].

SUMMARY OF REVIEW/REVISIONS	DATE
REVISION-Notable revisions: Required Medical Information Continuation of Therapy Compendial Approved Off-Labeled Uses Contraindications References	Q2 2024
REVISION-Notable revisions: Required Medical Information Continuation of Therapy Prescriber Requirements References	Q2 2023
NEW CRITERIA CREATION	Q2 2022