VENTURA COUNTY
HEALTH CARE PLAN

# PRIOR AUTHORIZATION POLICY

**POLICY:** Oncology – Vonjo Prior Authorization Policy
- Vonjo™ (pacritinib capsules – CTI BioPharma)

**REVIEW DATE:** 03/02/2022; selected revision 06/22/2022

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## OVERVIEW

Vonjo, an inhibitor of Janus Associated Kinase (*JAK)* 2 and FMS-like tyrosine kinase (*FLT3*), is 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 $50 \times 10^9$ /L.

## Guidelines

National Comprehensive Cancer Network (NCCN) guidelines for myeloproliferative neoplasms (version 1.2022 – February 28, 2022) state that Vonjo has demonstrated significant activity resulting in ≥ 35% spleen volume reduction and symptom improvement, even in patients with severe baseline cytopenias.[2] Vonjo could be an appropriate treatment option for patients with low platelet counts, however it is not FDA approved yet. For patients with higher-risk myelofibrosis with platelet count $< 50 \times 10^9$ /L, the guidelines recommend either allogeneic hematopoietic stem cell transplant or enrollment in a clinical trial for those who are not candidates for transplant. The guidelines recommend Jakafi® (ruxolitinib tablets) and Inrebic® (fedratinib capsules) for patients with higher-risk myelofibrosis when platelet count is $\geq 50 \times 10^9$ /L (both category 1).

## POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Vonjo. All approvals are provided for the duration note.

**Automation:** none

## RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Vonjo is recommended in those who meet the following criteria:

### FDA-Approved Indications

1. **Myelofibrosis (MF), including Primary MF, Post-Polycythemia Vera MF, and Post-Essential Thrombocythemia MF.** Approve for 1 year if the patient meets the following criteria (A, B, and C):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has intermediate risk or high risk disease; AND
   - **C)** Patient has a platelet count of less than $50 \times 10^9$ /L (< 50,000/mcL).

## CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Vonjo is not recommended in the following situations:

**1.** Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

## REFERENCES

1. Vonjo® capsules [prescribing information]. Seattle, WA: CTI BioPharma; February 2022.
2. The NCCN Myeloproliferative Neoplasms Clinical Practice Guidelines in Oncology (version 1.2022 – February 28, 2022). © 2022 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on March 1, 2022

| Type of Revision | Summary of Changes | Review Date |
|---|---|---|
| New Policy | -- | 03/02/2022 |
| Selected Revision | **Myelofibrosis (MF), including Primary MF, Post-Polycythemia Vera MF, and Post-Essential Thrombocythemia MF:** The duration of approval was changed from 3 years to 1 year. | 06/22/2022 |