Clinical Policy: Pacritinib (Vonjo)

Reference Number: CP.PHAR.583
Effective Date: 06.01.22
Last Review Date: 05.23
Line of Business: Commercial, HIM, Medicaid

Revision Log

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

Description

Pacritinib (Vonjo™) is a kinase inhibitor.

FDA Approved Indication(s)

Vonjo is indicated for the treatment of adults with intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF) with a platelet count below 50×10^9/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(s).

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.

It is the policy of health plans affiliated with Centene Corporation® that Vonjo is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of primary or secondary (post-polycythemia vera or post-essential thrombocythemia) MF;
2. Member meets one of the following (a or b):
   a. Documentation of a recent (within the last 30 days) platelet count of $< 50 \times 10^9$/L and one of the following (i, ii or ii):
      i. Disease is intermediate-risk;
      ii. Disease is high-risk;
      iii. Both of the following (a and b):
         a) Disease is lower-risk (*see Appendix D*);
         b) Failure of ruxolitinib, peginterferon alfa-2a, or hydroxyurea (*see Appendix B*), unless clinically significant adverse effects are experienced or all are contraindicated;
         **Prior authorization may be required for hydroxyurea, peginterferon alfa-2a, and ruxolitinib*
   b. Documentation of recent (within the last 30 days) platelet count of ≥ 50 x 10^9/L and all of the following (i, ii, and iii):
      i. Disease is higher-risk;

ii. Member is not a candidate for allogenic hematopoietic stem cell transplantation;
iii. Failure of ruxolitinib or fedratinib (*see Appendix B*), unless clinically significant adverse effects are experienced or both are contraindicated;

3. Prescribed by or in consultation with a hematologist or oncologist;
4. Age ≥ 18 years;
5. For Vonjo requests, member must use pacritinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Request meets one of the following (a or b):*
   a. Dose does not exceed both of the following (i and ii):
      i. 400 mg per day;
      ii. 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: 6 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

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

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Vonjo for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Vonjo requests, member must use pacritinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed both of the following (i and ii):
      i. 400 mg per day;

ii. 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: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

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 policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
MF: myelofibrosis

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Jakafi® (ruxolitinib)	Varies	20 mg twice daily
Pegasys® (peginterferon alfa-2a)*	180 mcg SC once weekly	180 mcg/week
hydroxyurea (Droxia®, Hydrea®)	Varies	Varies
Inrebic® (fedratinib)	400 mg PO daily	400 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic

**Off label*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): concomitant use of strong CYP3A4 inhibitors or inducers
- Boxed warning(s): none

Appendix D: General Information

- The Dynamic International Prognostic Scoring System (DIPSS) was used in the pivotal trial for Vonjo (Persist-2) to determine disease risk. The scoring system and risk group stratification is provided below.

Prognostic Variable	Points		
	0	1	2
Age (years)	≤ 65	> 65	
White blood cell count ($x10^9$/L)	≤ 25	> 25	
Hemoglobin (g/dL)	≥ 10		< 10
Precent peripheral blood blast	< 1	≥ 1	
Constitutional symptoms (Yes or No)	No	Yes	

Risk Group	Points
Low	0
Intermediate-1 (INT-1)	1 or 2
Intermediate-2 (INT-2)	3 or 4
High	5 or 6

- The NCCN Myelofibrosis v3.2022 guideline stratifies risk for myelofibrosis into two categories, lower- and higher-risk. The categories include the following grading scales: mutation-enhanced IPSS for age ≤ 70 (MIPSS-70), mutation and karyotype-enhanced IPSS (MIPSS-70+ version 2.0) DIPSS, DIPSS-Plus and Myelofibrosis secondary to PV and ET-prognostic model (MYSEC-PM). The risk group with corresponding points scale is provided below. Please refer to the guidelines for additional details on the prognostic variables for each grading scale.

Risk Group	Points
Lower-risk	MIPSS-70 ≤ 3 MIPSS-70+ version 2.0: ≤ 3 DIPSS-Plus: ≤ 1 DIPSS: ≤ 2 MYSEC-PM: < 14
Higher-risk	MIPSS-70 ≥ 4 MIPSS-70+ version 2.0: ≥ 4 DIPSS-Plus: > 1 DIPSS: > 2 MYSEC-PM: ≥ 14

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MF	200 mg PO BID	400 mg/day

VI. Product Availability

Capsule: 100 mg

VII. References

1. Vonjo Prescribing Information. Seattle, WA: CTI BioPharma Corp.; February 2022. Available at: https://www.ctibiopharma.com/wp-content/uploads/2022/03/VONJO_PI_02-2022.pdf. Accessed January 24, 2023.
2. Mascarenhas J, Hoffman R, Talpaz M, et al. Pacritinib vs best available therapy, including ruxolitinib, in patients with myelofibrosis: a randomized clinical trial. JAMA Oncol. 2018 May;4(5):652-659.
3. National Comprehensive Cancer Network. Myeloproliferative Neoplasms Version 3.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/mpn.pdf. Accessed January 24, 2023.
4. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed January 24, 2023.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	03.08.22	05.22
Template changes applied to other diagnoses/indications.	10.07.22	
2Q 2023 annual review: for MF added criteria for lower-risk disease per NCCN 2A recommendation and added criteria for higher-risk disease with platelets ≥ 50 x 10^9/L per NCCN 1 recommendation; for continued therapy section updated FDA maximum dosing to mirror PI; provided details on risk stratification in Appendix D; references reviewed and updated.	02.20.23	05.23

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. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. 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. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.