Mass General Brigham
Health Plan

Inrebic (fedratinib)
Effective 10/01/2021

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit (NLX)		
Specialty Limitations	N/A		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview

Fedratinib is a kinase inhibitor with activity against both wild-type and mutated Janus-associated kinase 2 (JAK2) and FMS-like tyrosine kinase 3 (FLT3). Fedratinib is selective for JAK2, with higher inhibitory activity for JAK2 (versus JAK1, JAK3, and TYK2). Abnormal JAK2 activation is associated with myeloproliferative neoplasms, including myelofibrosis and polycythemia vera. Fedratinib reduces phosphorylation of signal transducer and activator of transcription (STAT3/5) proteins, inhibits cell proliferation, and induces apoptosis in mutated JAK2 and FLT3 cell lines, improving WBC counts, hematocrit, splenomegaly, and fibrosis.

Coverage Guidelines

Authorization may be granted for members new to the plan who are currently receiving treatment with Inrebic, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization may be granted if the member meets all following criteria and documentation has been submitted:

1. The member has medical records and genetic testing supporting diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis
2. The member is ≥ 18 years of age
3. The member has a baseline platelet count of greater than or equal to 50 x 10^9/L (≥50,000/mm3).

Continuation of Therapy

Reauthorization may be granted for members who have met the initial criteria and the physician has submitted clinical documentation of 35% or greater reduction in spleen volume from baseline.

Limitations

1. Initial approvals will be granted for 6 months
2. Reauthorization may be granted for 12 months

Dosing

Inrebic 100mg	120 capsules per 30 days

References

1. Inrebic (fedratinib) [prescribing information]. Summit, NJ: Celgene Corporation; December 2021.

Review History

05/20/2020 – Reviewed and approved May P&T. Effective 07/01/20
01/01/2021 – Separated MH from ComExch
07/21/2021 - Reviewed July P&T; updated started and stabilized statement to say, “members new to the plan”. Effective 10/01/2021.
09/21/2022 - Reviewed at Sept P&T; references updated; no clinical changes.