Reference number
3161-A

SPECIALTY GUIDELINE MANAGEMENT

INREBIC (fedratinib)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications
Inrebic is indicated for the treatment of adult patients with intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF).

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Myelofibrosis
Authorization of 12 months may be granted for the treatment of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF).

III. CONTINUATION OF THERAPY

Myelofibrosis
Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in Section II who have improvement in symptoms and no unacceptable toxicity.

IV. REFERENCES

1. Inrebic [package insert]. Summit, NJ: Celgene Corporation; August 2019.

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