Applicable Drugs: Vonjo (pacritinib)

Preferred: N/A

Non-preferred: N/A

Date of Origin: 8/29/2022

Date Last Reviewed / Revised: 7/23/2026

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I through V are met)

I. Documentation of the following FDA-approved diagnosis AND must meet all criteria listed under the applicable diagnosis:

FDA-Approved Indication(s)

A. Intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis and criteria i and ii are met:

i. Documentation of thrombocytopenia (platelet count below 50 × 10^9/L).

ii. Physician attestation stating that the patient is not a transplant candidate or that the patient does not wish to pursue allogenic hematopoietic cell transplant.

Other Uses With Supportive Evidence

B. Myeloid/lymphoid neoplasms

C. Myeloproliferative neoplasms

II. Minimum age requirement: 18 years old.

III. Treatment must be prescribed by or in consultation with an oncologist or hematologist.

IV. Request is for a medication with the appropriate FDA labeling, or its use is supported by current National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1 or 2A.

V. Refer to the plan document for the list of preferred products. If the requested agent is not listed as a preferred product, must have documented treatment failure or contraindication to the preferred product(s).

EXCLUSION CRITERIA

- Concomitant use of strong CYP3A4 inhibitors or inducers.

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- Quantities of up to 120 tablets per 30 days.

APPROVAL LENGTH

- **Authorization:** 1 year.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

APPENDIX

N/A

REFERENCES

1. Vonjo (pacritinib). Prescribing information. Sobi Inc. 2026. Accessed June 11, 2026. https://www.vonjo.com/sites/default/files/2024-09/prescribing-information.pdf
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;4(5):652-659.
3. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Myeloproliferative Neoplasms. Version 2.2026. Updated June 16, 2026. Accessed July 23, 2026. https://www.nccn.org/professionals/physician_gls/pdf/mpn.pdf
4. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions. Version 1.2026. Updated October 3, 2025. Accessed July 23, 2026. https://www.nccn.org/professionals/physician_gls/pdf/mlne.pdf

DISCLAIMER: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.