



Wellmark Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

DRUG POLICY

Inrebic (fedratinib)

NOTICE

This policy contains information which is clinical in nature. The policy is not medical advice. The information in this policy is used by Wellmark to make determinations whether medical treatment is covered under the terms of a Wellmark member's health benefit plan. Physicians and other health care providers are responsible for medical advice and treatment. If you have specific health care needs, you should consult an appropriate health care professional. If you would like to request an accessible version of this document, please contact customer service at 800-524-9242.

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

The intent of the Inrebic (fedratinib) drug policy is to provide coverage consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines. The indications below including FDA-approved indications and compendial uses are considered covered benefits 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).

Compendial Use

1. Treatment for myeloid/lymphoid neoplasms with eosinophilia and JAK2 rearrangement in chronic phase
2. Treatment for myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement in blast phase
3. Treatment for myeloproliferative neoplasms in accelerated phase or blast phase
4. Treatment for splenomegaly and other disease-related symptoms of MF-associated anemia

POLICY

Required Documentation

Submission of the following information is necessary to initiate the prior authorization review:

- A. Testing or analysis confirming JAK2 rearrangement (if applicable).

Criteria for Initial Approval

A. Myelofibrosis/Myeloproliferative Neoplasms

Authorization of 12 months may be granted for the treatment of myelofibrosis/myeloproliferative neoplasms when the member has a diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF), splenomegaly and other disease-related symptoms of MF-associated anemia (e.g., fatigue, weakness, shortness of breath, pale skin), accelerated phase or blast phase myeloproliferative neoplasms.

B. Myeloid/Lymphoid Neoplasms

Authorization of 12 months may be granted for the treatment of myeloid and/or lymphoid neoplasms with eosinophilia and JAK2 rearrangement in the chronic phase or blast phase.

Continuation of Therapy

A. Myelofibrosis/Myeloproliferative Neoplasms

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization when there is no evidence of unacceptable toxicity and there has been an improvement in symptoms.

B. Myeloid/Lymphoid Neoplasms

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

Other

Inrebic (fedratinib) is considered not medically necessary for members who do not meet the criteria set forth above.

Dosing and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Quantity Limits

Drug Name	Quantity Limit	FDA-recommended dosing
Inrebic (fedratinib) 100 mg capsule	120 capsules per 30 days	400 mg orally once daily

PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

REFERENCES

- Inrebic [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; May 2025.
- The NCCN Drugs & Biologics Compendium®©2026 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed January 12, 2026.

POLICY HISTORY

Policy #: 05.05.25

Original Effective Date: March 16, 2024

Reviewed: August 2026

Revised: August 2026

Current Effective Date: September 14, 2026