

PHARMACY POLICY STATEMENT

2. Medication must be prescribed by or in consultation with a transplant or hematology/oncology specialist; AND
3. Member has a documented diagnosis of moderate to severe cGVHD; AND
4. Member's condition is steroid refractory or dependent (with or without a calcineurin inhibitor): Lack of response or disease progression after at least 1 week (e.g., on prednisone 1mg/kg/day), persistence without improvement after at least 4 weeks, or at least 2 failed taper attempts.
5. **Dosage allowed/Quantity limit:** 10 mg twice daily. (60 tablets per 30 days).

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show improvement of signs and symptoms of disease in at least 1 organ/site, without progression in any other organ/site.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Myelofibrosis

Any request for cancer must be submitted through [NantHealth/Eviti](#) portal.

Polycythemia Vera

Any request for cancer must be submitted through [NantHealth/Eviti](#) portal.

8. National Comprehensive Cancer Network. Hematopoietic Cell Transplantation (HCT): Pre