BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINE

JAKAFI® (ruxolitinib phosphate) oral
JAKAFI XR™ (ruxolitinib phosphate) extended-release oral
Generic Equivalent (if available)

This Pharmacy Coverage Guideline (PCG):
- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively "Service") is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider's judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member's benefit plan; and
- Is subject to change as new information becomes available.

Scope
- This PCG applies to Commercial and/or Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

Instructions & Guidance
- To determine whether a member is eligible for the Service, read the entire PCG.
- This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
- Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
- The "Criteria" section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member's benefit plan.
- The "Description" section describes the Service.
- The "Definition" section defines certain words, terms or items within the policy and may include tables and charts.
- The "Resources" section lists the information and materials we considered in developing this PCG
- **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
- Information about medications that require prior authorization is available at www.azblue.com/pharmacy. You must fully complete the request form and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to Pharmacyprecert@azblue.com.

Medical Necessity Requirements for JAKAFI (ruxolitinib phosphate), JAKAFI XR (ruxolitinib phosphate) extended release

Criteria for Initial Therapy:

Prescriber Qualifications
- Prescribed by a physician specializing in the diagnosis or in consultation with an Oncologist or Hematologist

ORIGINAL EFFECTIVE DATE: 05/07/2015 | ARCHIVE DATE: | LAST REVIEW DATE: 05/21/2026 | LAST CRITERIA REVISION DATE: 05/21/2026

PHARMACY COVERAGE GUIDELINE

JAKAFI® (ruxolitinib phosphate) oral
JAKAFI XR™ (ruxolitinib phosphate) extended-release oral
Generic Equivalent (if available)

Indication

- Treatment of intermediate or high risk myelofibrosis (includes primary myelofibrosis, post polycythemia vera myelofibrosis, and post essential thrombocythemia myelofibrosis)
- Treatment of polycythemia vera in individuals with failure, contraindication, or intolerance to hydroxyurea
- Treatment of steroid refractory acute graft versus host disease following hematopoietic cell transplantation
- Treatment of chronic graft versus host disease following hematopoietic cell transplantation after failure of one or two lines of systemic therapy
- Other oncologic direct treatment uses listed in National Comprehensive Cancer Network (NCCN) Guidelines with Categories of Evidence and Consensus of 1 and 2A

Age Requirement

- 12 years or older for acute and chronic graft versus host disease
- 18 years or older for myelofibrosis and polycythemia vera

Baseline Clinical Evaluation

- Assessment of past infections including tuberculosis, herpes simplex, herpes zoster, and hepatitis B
- No unresolved active infections prior to initiation
- Complete blood count

Alternative Therapies

- Failure (trial for at least three months duration), contraindication, intolerance to hydroxyurea (for polycythemia vera)

Brand Specific Criteria

- Have failure, contraindication, or intolerance with **THREE** generic equivalents (if available) for at least three months each. **Note:** Any failure, contraindication, or intolerance to the generic drugs should be reported to the U.S. Food and Drug Administration (FDA) (see Definitions section)

Safety

- No concomitant use with other Tyrosine Kinase Inhibitors or Janus Associated Kinase Inhibitors (such as tofacitinib, tofacitinib XR, baricitinib, upadacitinib, or fedratinib)
- Does not have ESRD (creatinine clearance less than 15 mL/min) not requiring dialysis

Documentation Requirements

- A completed request form must be submitted, including:
  - Chart notes
  - Lab results (CBC)
  - Supporting clinical documentation

PHARMACY COVERAGE GUIDELINE

JAKAFI® (ruxolitinib phosphate) oral
JAKAFI XR™ (ruxolitinib phosphate) extended-release oral
Generic Equivalent (if available)

Initial Therapy Criteria Approval Duration:
- 6 months OR end of plan year

Criteria for Continuation of Therapy (renewal therapy)
Note: Manufacturer assistance (e.g., coupons, samples, etc.) are not considered for continuation of therapy

Prescriber Qualification
- Continues to be seen by a physician specializing in or is in consultation with an Oncologist or Hematologist

Clinical Response
- No evidence of disease progression or unacceptable toxicity

Adherence
- Adherence to the prescribed therapy regimen has been documented

Brand Specific Criteria
- Have failure, contraindication, or intolerance with **THREE** generic equivalents (if available) for at least three months each. **Note:** Any failure, contraindication, or intolerance to the generic drugs should be reported to the FDA (see Definitions section)

Safety
- No significant adverse drug effects such as:
  - Progressive multifocal leukoencephalopathy
  - Thrombocytopenia
  - Neutropenia
  - Anemia
- No concomitant use with other Tyrosine Kinase Inhibitors or Janus Associated Kinase Inhibitors (such as tofacitinib, tofacitinib XR, baricitinib, upadacitinib, or fedratinib)
- Does not have end stage renal disease (creatinine clearance less than 15 mL/min) not requiring dialysis

Documentation Requirements
- Chart notes
- Supporting clinical documentation with evidence of improvement in given indication
- Lab values that confirm safe use

Continuation Therapy Criteria Approval Duration:
- 12 months OR end of plan year

PHARMACY COVERAGE GUIDELINE

JAKAFI® (ruxolitinib phosphate) oral
JAKAFI XR™ (ruxolitinib phosphate) extended-release oral
Generic Equivalent (if available)

Criteria for Off-Label Use Requests:

Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. Off-Label Use of Non-Cancer Medications
2. Off-Label Use of Cancer Medications

Description:

Jakafi (ruxolitinib) and Jakafi XR (ruxolitinib) are indicated for: adult patients with intermediate or high-risk myelofibrosis (MF), including primary myelofibrosis (PMF), post-polycythemia vera myelofibrosis (Post-PV MF) and post-essential thrombocythemia myelofibrosis (Post ET MF); adult polycythemia vera (PV) who have had an inadequate response to or are intolerant of hydroxyurea; and it is also indicated for patients 12 years and older with steroid-refractory acute and chronic graft-versus-host disease (aGVHD) and chronic graft-versus-host disease (cGVHD) after failure of one or two lines of systemic therapy.

Ruxolitinib is a kinase inhibitor of the Janus-associated kinases (JAK), JAK1 and JAK2. There are 4 known JAK: JAK1, JAK2, JAK3, and tyrosine kinase 2 (TyK2). JAK are intracellular enzymes that transmit signals coming from cytokine or growth factor receptor interactions on the cell membrane to influence hematopoiesis and immune cell function. Receptor binding of these kinases initiates intracellular signal pathways that regulate the transcription of genes for several cell products. JAK enzymes transmit signals through pairing of JAK (such as JAK1-JAK3, JAK1-JAK2, JAK1-TyK2, and JAK2-JAK2). Within the signaling pathway, JAK phosphorylate and activate Signal Transducers and Activators of Transcription (STATs) which modulate intracellular activity including gene expression. Interruption of these signaling pathways is thought to reduce the inflammatory response. MF and PV are myeloproliferative neoplasms known to be associated with uncontrolled and overactive JAK1 and JAK2 signaling. Inhibition of this overactivity results in a decrease in the inflammatory cytokine signaling and a decrease in overproduction of cells. JAK-STAT signaling pathways play a role in regulating the development, proliferation, and activation of several immune cell types important for GVHD pathogenesis.

MF, a Philadelphia chromosome-negative chronic myeloproliferative disorder, is characterized by progressive anemia, bone marrow fibrosis, splenomegaly and constitutional symptoms. Up to 30% of patients are initially asymptomatic. Many patients present with symptoms from anemia, splenomegaly or constitutional symptoms (severe fatigue, low grade fever, pruritus, night sweats and weight loss). As the disease evolves, all patients become symptomatic due to marrow failure and increasing splenomegaly resulting in abdominal symptoms and early satiety.

Current drug therapy is palliative and efficacy is variable. Allogeneic stem cell transplantation is potentially curative but is not appropriate for all patients. Treatment for MF may include androgens, corticosteroids, erythropoiesis-stimulating agents, thalidomide, lenalidomide, and hydroxyurea. Splenectomy can be considered in transfusion dependent anemia that is refractory to drug therapy.

The International Working Group (IWG) consensus for Myelofibrosis Research and Treatment has devised an international prognostic scoring system (IPSS) that uses presenting signs and symptoms to assign risk

categories. Individuals with zero (low risk), one (intermediate risk-1), two (intermediate risk-2), or ≥3 (high risk) at presentation had non-overlapping median survivals of 135, 95, 48, and 27 months, respectively. The following five adverse prognostic features were noted by the IWP IPSS: age > 65 years; presence of constitutional symptoms (weight loss >10 % from baseline, night sweats, or unexplained fever); hemoglobin <10 g/dL; leukocyte count > 25 X 10^9/L; and circulating blast cells ≥ 1%.

PV is a chronic myeloproliferative disorder that causes the bone marrow to produce too many red blood cells. The median age at presentation is 60 years. Patients often present with either arterial or venous vascular occlusive events. The events are predominantly coronary and cerebral but can involve the skin and gastrointestinal tract. Over time PV may evolve to MF, acute myeloid leukemia (AML), or myelodysplastic syndrome (MDS). The mainstay of therapy for PV is phlebotomy which removes excess red blood cells and lowers blood viscosity. In general, the goal of phlebotomy is to keep the hematocrit below 45% in men and 42% in women. When patients remain symptomatic despite phlebotomy, other options include hydroxyurea (with or without phlebotomy), interferon alfa, thalidomide, lenalidomide, anagrelide (in certain circumstances) and rarely, chlorambucil, melphalan, or busulfan. It is estimated that 25% of PV patients remain uncontrolled despite the use of existing standard therapies.

Graft-versus host disease (GVHD) is a multisystem disorder and is a major complication of allogeneic hematopoietic cell transplant (HCT). GVHD occurs when immune cells transplanted from a non-identical donor (the graft) recognizes the transplant recipient (the host) as foreign, and as a result an immune reaction is initiated in the transplant recipient. GVHD is a syndrome of tissue inflammation and/or fibrosis affecting skin, gastrointestinal tract, liver, lungs, and mucosal surfaces.

GVHD is usually divided into acute GVHD (aGVHD) and chronic GVHD (cGVHD) based on the time of onset. Typically, aGVHD manifests as a maculopapular rash, weight loss, diarrhea, and/or hepatitis within 100 days of transplantation while cGVHD manifests as fibrosis of skin, lungs, GI tract, and soft tissues that presents at least 100 days after transplantation. However, it has been recognized that acute and chronic GVHD may occur outside of these time periods. This has led to use of clinical findings, rather than a set time, to differentiate between acute and chronic forms of GVHD. The widely accepted National Institutes of Health (NIH) consensus criteria for the diagnosis of GVHD includes an overlap syndrome in which diagnostic or distinctive features of cGVHD and aGVHD appear together.

Patients with GVHD can be classified based on the timing of presentation and the features present:

- **Classic aGVHD** presenting within 100 days of HCT and displaying features of aGVHD. Diagnostic and distinctive features of cGVHD are not present
- **Persistent, recurrent, late onset aGVHD** presenting greater than 100 days post-HCT with features of aGVHD and diagnostic and distinctive features of cGVHD are not present
- **Classic cGVHD** presenting at any time post-HCT with diagnostic and distinctive features of cGVHD present. There are no features of aGVHD
- **Overlap syndrome c**ases may present at any time post-HCT with features of both cGVHD and aGVHD. This is sometimes referred to as "acute on chronic" GVHD]

Definitions:

U.S. Food and Drug Administration (FDA) MedWatch Forms for FDA Safety Reporting

MedWatch Forms for FDA Safety Reporting | FDA

Myelofibrosis:

These risk stratification systems have been studied and validated only in patient with PMF, but clinically have been used for stratification of patients with Post-PV MF or Post-ET MF. Novel prognostic models are being developed for risk stratification of patients with Post-PV MF or Post-ET MF

IPSS should be used at time of diagnosis, DIPSS-PLUS is preferred during the course of treatment, DIPSS can be used if karyotyping is not available

International Working Group (IWG) International prognostic scoring system (IPSS):

Risk Stratification for Myelofibrosis (IPSS)	
	Points
Age > 65 years	1
Constitutional symptoms: Weight loss > 10 % from baseline Night sweats Unexplained fever	1
Hemoglobin <10 g/dL	1
Leukocyte count > 25 X 10^9/L	1
Circulating blast cells ≥ 1%	1
Risk Group	
Low risk	0 points
Intermediate risk-1	1 point
Intermediate risk-2	2 points
High risk	3 or more points

Dynamic International Prognostic System (DIPSS):

Prognostic Variable	Points		
	0	1	2
Age (y)	≤ 65	> 65	
Constitutional symptoms (Y/N)	N	Y	
Hemoglobin (g/dL)	≥ 10		< 10
WBC (x 10^9/L)	≤ 25	> 25	
Peripheral blood blasts (%)	< 1	≥ 1	
Risk Group	Points		
Low	0		
Intermediate-1	1 or 2		

Intermediate-2	3 or 4		
High	5 or 6		

Dynamic International Prognostic System Plus (DIPSS-Plus):

Prognostic Variable	Points
DIPSS low risk	0
DIPSS Intermediate-1	1
DIPSS Intermediate-2	2
DIPSS high risk	3
Platelets < 100 x 10^9/L	1
Transfusion need	1
Unfavorable karyotype*	1
Risk Group	Points
Low	0
Intermediate-1	1
Intermediate-2	2 or 3
High	4 to 6
*Unfavorable karyotype: complex karyotype or sole or two abnormalities that include trisomy 8, 7/7q, i(17q), 5/5q-, 12p-, inv(3), or 11q23 rearrangement	

Assessment of Symptom Burden:

MPN-SAF is recommended for assessment at baseline and MPN-SAF TSS is recommended for monitoring during the course of treatment

Myeloproliferative Neoplasm Symptom Assessment Form (MPN-SAF)		
	Circle the one number that describes, **during the past week**, how much difficulty you had with each of the following symptoms	
Early satiety	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Abdominal pain	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Abdominal discomfort	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Inactivity	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Problems with headaches	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Problems with concentration compared to before Dx	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Dizziness/vertigo/lightheaded	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Numbness tingling hands/feet	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Difficulty sleeping	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10

Depressed or sad mood	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Problems with sexual desire or ability	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Cough	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Night sweats	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Itching	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Bone pain – not joint pain or arthritis	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Unintentional weight loss	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Fever	Absent = 0; Daily = 10	0-1-2-3-4-5-6-7-8-9-10
Overall quality of life	As good as it can be = 0; As bad as it can be = 10	0-1-2-3-4-5-6-7-8-9-10

Myeloproliferative Neoplasm Symptom Assessment Form Total Symptom Score (MPN-SAF TSS; MPN 10)		
Rate fatigue (weariness, tiredness) that describes your worst level of fatigue **during the past 24 hours**	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Circle the one number that describes, **during the past week**, how much difficulty you had with each of the following symptoms		
Early satiety	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Abdominal discomfort	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Inactivity	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Problems with concentration compared to before Dx	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Numbness tingling hands/feet	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Night sweats	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Itching	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Bone pain – not joint pain or arthritis	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Unintentional weight loss	Absent = 0; Worst imaginable = 10	0-1-2-3-4-5-6-7-8-9-10
Fever	Absent = 0; Daily = 10	0-1-2-3-4-5-6-7-8-9-10

Polycythemia vera:

Low-risk patients
- Age < 60 years
- No history of thrombosis

High-risk patients:
- Age ≥ 60 years
- History of thrombosis

Potential indications for cytoreductive therapy:
- New thrombosis or disease related major bleeding
- Frequent and/or persistent need for phlebotomy, but with poor tolerance for phlebotomy
- Splenomegaly
- Thrombocytosis

Leukocytosis
Disease related symptoms (e.g., pruritus, night sweats, fatigue)

Mount Sinai Acute GVHD International Consortium (MAGIC):

Organ Severity Stage	MAGIC Criteria
Skin	
0	No rash
1	Maculopapular rash < 25% BSA
2	Maculopapular rash 25-50% BSA
3	Maculopapular rash > 50% BSA
4	Generalized erythroderma (> 50% BSA) plus bullous formation and desquamation > 5% BSA
Liver	
0	Total serum bilirubin < 34 micromol/L (< 2 mg/dL)
1	Total serum bilirubin 34-50 micromol/L (2-3 mg/dL)
2	Total serum bilirubin 51-102 micromol/L (3.1-6 mg/dL)
3	Total serum bilirubin 103-255 micromol/L (6.1-15 mg/dL)
4	Total serum bilirubin > 255 micromol/L (> 15 mg/dL)
Upper GI	
0	No or intermittent[a] anorexia or nausea or vomiting
1	Persistent[a] anorexia or nausea or vomiting
Lower GI	
0	Diarrhea < 500 mL/day or < 3 episodes/d for adult[b,c]
1	Diarrhea 500-999 mL/day or 3-4 episodes/d for adult[b,d]
2	Diarrhea 1000-1500 mL/day or 5-7 episodes/d for adult[b,e]
3	Diarrhea > 1500 mL/day or > 7 episodes/d for adult[b,f]
4	Severe abdominal pain with or without ileus or grossly bloody stools regardless of stool volume

[a]To be suggestive for GVHD: anorexia should be accompanied by weight loss, nausea should be at least 3 days, or be accompanied by at least 2 vomiting episodes per day for at least 2 days

[b]One episode of diarrhea is considered to be about 200 mL for an adult and 3 mL/kg for a child (< 50 kg)

[c]Diarrhea < 10 mL/kg/day or < 4 episodes/day for children

[d]Diarrhea 10-19.9 mL/kg/day or 4-6 episodes/day for children

[e]Diarrhea 20-30 mL/kg/day or 7-10 episodes/day for children

[f]Diarrhea > 30 mL/kg/day or > 10 episodes/day for children

Stage	Skin (active erythema only)	Liver (total bilirubin)	Upper GI	Lower GI (stool output)
0	No active (erythematous) GVHD rash	< 34 µmol/L (< 2 mg/dL)	No or intermittent[a] anorexia or nausea or vomiting	< 500 mL/day or < 3 episodes/d for adult < 10 mL/kg/day or < 4 episodes/day for children[b]
1	Maculopapular rash < 25% BSA	34-50 µmol/L (2-3 mg/dL)	Persistent[a] anorexia or nausea or vomiting	500-999 mL/day or 3-4 episodes/d for adult[b] 10-19.9 mL/kg/day or 4-6 episodes/day for children
2	Maculopapular rash 25-50% BSA	51-102 µmol/L (3.1-6 mg/dL)	--	1000-1500 mL/day or 5-7 episodes/d for adult[b] 20-30 mL/kg/day or 7-10 episodes/day for children
3	Maculopapular rash > 50% BSA	103-255 µmol/L (6.1-15 mg/dL)	--	> 1500 mL/day or > 7 episodes/d for adult[b] > 30 mL/kg/day or > 10 episodes/day for children
4	Generalized erythroderma (> 50% BSA) plus bullous formation & desquamation > 5% BSA	> 255 µmol/L (> 15 mg/dL)	--	Severe abdominal pain with or without ileus or grossly bloody stools regardless of stool volume

[a]To be suggestive for GVHD: anorexia should be accompanied by weight loss, nausea should be at least 3 days, or be accompanied by at least 2 vomiting episodes per day for at least 2 days

[b]One episode of diarrhea is considered to be about 200 mL for an adult and 3 mL/kg for a child (< 50 kg)

Overall clinical grade (based upon most severe target organ involvement):

Grade 0: No stage 1–4 of any organ
Grade I: Stage 1–2 skin without liver, upper GI or lower GI involvement
Grade II: Stage 3 rash and/or stage 1 liver and/or stage 1 upper GI and/or stage 1 lower GI
Grade III: Stage 2–3 liver and/or stage 2–3 lower GI, with stage 0–3 skin and/or stage 0–1 upper GI
Grade IV: Stage 4 skin, liver or lower GI involvement, with stage 0–1 upper GI

NCCN recommendation definitions:

Category 1:
Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

Category 2A:
Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

Category 2B:
Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.

Category 3:
Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate

PHARMACY COVERAGE GUIDELINE

JAKAFI® (ruxolitinib phosphate) oral
JAKAFI XR™ (ruxolitinib phosphate) extended-release oral
Generic Equivalent (if available)

Resources:

Jakafi (ruxolitinib) & Jakafi XR (ruxolitinib) extended release product information, revised by Incyte Corporation. 05-2026. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed May 12, 2026.

Tefferi A. Management of primary MF and secondary MF. In: UpToDate, Larson RA, Rosmarin AG (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through February 2026. Topic last updated December 19, 2025. Accessed March 16, 2026.

Tefferi A. Polycythemia vera and secondary polycythemia: Treatment and prognosis. In: UpToDate, Larson RA, Rosmarin AG (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through February 2026.Topic last updated February 27, 2024. Accessed March 16, 2026.

Zeiser R. Treatment of acute graft-versus-host disease. In: UpToDate, Negrin RS, Chao NJ, Rosmarin AG (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through February 2026. Topic last updated December 04, 2025. Accessed March 16, 2026.

Zeiser R. Treatment of chronic graft-versus-host disease. In: UpToDate, Negrin RS, Chao NJ, Rosmarin AG (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through February 2026.Topic last updated September 25, 2024. Accessed March 16, 2026.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Myeloproliferative Neoplasms Version 1.2026 – Updated January 22, 2026. Available at https://www.nccn.org. Accessed March 16, 2026.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Hematopoietic Cell Transplantation (HCT) Version 3.2025 – Updated September 24, 2025. Available at https://www.nccn.org. Accessed March 16, 2026.

Off Label Use of Cancer Medications: A.R.S. §§ 20-826(R) & (S). Subscription contracts; definitions.

Off Label Use of Cancer Medications: A.R.S. §§ 20-1057(V) & (W). Evidence of coverage by health care service organizations; renewability; definitions.