JAKAFI® (ruxolitinib) tablets, for oral use
Initial U.S. Approval: 2011

**INDICATIONS AND USAGE**

Jakafi is a kinase inhibitor indicated for treatment of patients with:

- intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocytopenia myelofibrosis. (1.1)
- polycythemia vera who have had an inadequate response to or are intolerant of hydroxyurea. (1.2)

**DOSAGE AND ADMINISTRATION**

Doses should be individualized based on safety and efficacy. Starting doses per indication are noted below.

**Myelofibrosis (2.1)**

- The starting dose of Jakafi is based on patient’s baseline platelet count:
  - Greater than 200 X 10^9/L: 20 mg given orally twice daily
  - 100 X 10^9/L to 200 X 10^9/L: 15 mg given orally twice daily
  - 50 X 10^9/L to less than 100 X 10^9/L: 5 mg given orally twice daily
- Monitor complete blood counts every 2 to 4 weeks until doses are stabilized, and then as clinically indicated. Modify or interrupt dosing for thrombocytopenia.

**Polycythemia Vera (2.2)**

- The starting dose of Jakafi is 10 mg given orally twice daily.

**ADVERSE REACTIONS**

- The most common hematologic adverse reactions (incidence > 20%) are thrombocytopenia and anemia. The most common non-hematologic adverse reactions (incidence >10%) are bruising, dizziness and headache. (6.1)

**CONTRAINDICATIONS**

None. (4)

**WARNINGS AND PRECAUTIONS**

- Thrombocytopenia, Anemia and Neutropenia: Manage by dose reduction, or interruption, or transfusion. (5.1)
- Risk of Infection: Assess patients for signs and symptoms of infection and initiate appropriate treatment promptly. (5.2)
- Symptom Exacerbation Following Interruption or Discontinuation: Manage with supportive care and consider resuming treatment with Jakafi. (5.3)
- Risk of Non-Melanoma Skin Cancer: Perform periodic skin examinations. (5.4)
- Lipid Elevations: Assess lipid levels 8-12 weeks from start of therapy and treat as needed. (5.5)

**DRUG INTERACTIONS**

- Strong CYP3A4 Inhibitors or Fluconazole: Reduce, interrupt, or discontinue Jakafi doses as recommended. Avoid use of Jakafi with fluconazole doses greater than 200 mg. (2.3) (7)

**USE IN SPECIFIC POPULATIONS**

- Renal Impairment: Reduce Jakafi starting dose or avoid treatment as recommended. (2.4) (8.6)
- Hepatic Impairment: Reduce Jakafi starting dose or avoid treatment as recommended. (2.4) (8.7)
- Lactation: Advise not to breastfeed. (8.2)

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.
FULL PRESCRIBING INFORMATION

1. INDICATIONS AND USAGE

1.1 Myelofibrosis
Jakafi® (ruxolitinib) tablets are indicated for treatment of patients with intermediate- or high-risk myelofibrosis (MF), including primary MF, post-polycythemia vera MF, and post-essential thrombocythemia MF.

1.2 Polycythemia Vera
Jakafi® (ruxolitinib) tablets are indicated for treatment of patients with polycythemia vera (PV) who have had an inadequate response to or are intolerant of hydroxyurea.

2. DOSAGE AND ADMINISTRATION

2.1 Myelofibrosis

The recommended starting dose of Jakafi is based on platelet count (Table 1). A complete blood count (CBC) and platelet count must be performed before initiating therapy, every 2 to 4 weeks until doses are stabilized, and then as clinically indicated [see Warnings and Precautions (5.1)].

Doses may be titrated based on safety and efficacy.

Table 1:  Jakafi Starting Doses for Myelofibrosis

<table>
<thead>
<tr>
<th>Platelet Count</th>
<th>Starting Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than 200 X 10^9/L</td>
<td>20 mg orally twice daily</td>
</tr>
<tr>
<td>100 X 10^9/L to 200 X 10^9/L</td>
<td>15 mg orally twice daily</td>
</tr>
<tr>
<td>50 X 10^9/L to less than 100 X 10^9/L</td>
<td>5 mg orally twice daily</td>
</tr>
</tbody>
</table>

2.1.1 Dose Modification Guidelines for Hematologic Toxicity for Patients with Myelofibrosis Starting Treatment with a Platelet Count of 100 X 10^9/L or Greater

Treatment Interruption and Restarting Dosing

Interrupt treatment for platelet counts less than 50 X 10^9/L on a single occasion, or absolute neutrophil count (ANC) less than 0.5 X 10^9/L.

After recovery of platelet counts above 50 X 10^9/L and ANC above 0.75 X 10^9/L, dosing may be restarted. Table 2 illustrates the maximum allowable dose that may be used in restarting Jakafi after a previous interruption.

Table 2:  Myelofibrosis: Maximum Restarting Doses for Jakafi after Safety Interruption for Thrombocytopenia for Patients Starting Treatment with a Platelet Count of 100 X 10^9/L or Greater

<table>
<thead>
<tr>
<th>Current Platelet Count</th>
<th>Maximum Dose When Restarting Jakafi Treatment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than or equal to 125 X 10^9/L</td>
<td>20 mg twice daily</td>
</tr>
<tr>
<td>100 to less than 125 X 10^9/L</td>
<td>15 mg twice daily</td>
</tr>
<tr>
<td>75 to less than 100 X 10^9/L</td>
<td>10 mg twice daily for at least 2 weeks; if stable, may increase to 15 mg twice daily</td>
</tr>
<tr>
<td>50 to less than 75 X 10^9/L</td>
<td>5 mg twice daily for at least 2 weeks; if stable, may increase to 10 mg twice daily</td>
</tr>
<tr>
<td>Less than 50 X 10^9/L</td>
<td>Continue hold</td>
</tr>
</tbody>
</table>

*Maximum doses are displayed. When restarting, begin with a dose at least 5 mg twice daily below the dose at interruption.

Following treatment interruption for ANC below 0.5 X 10^9/L, after ANC recovers to 0.75 X 10^9/L or greater, restart dosing at the higher of 5 mg once daily or 5 mg twice daily below the largest dose in the week prior to the dose interruption.

Dose Reductions

Dose reductions should be considered if the platelet counts decrease as outlined in Table 3 with the goal of avoiding dose interruptions for thrombocytopenia.

Table 3:  Myelofibrosis: Dosing Recommendations for Thrombocytopenia for Patients Starting Treatment with a Platelet Count of 100 X 10^9/L or Greater

<table>
<thead>
<tr>
<th>Platelet Count</th>
<th>Dose at Time of Platelet Decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 mg twice daily</td>
<td>New Dose</td>
</tr>
<tr>
<td>20 mg twice daily</td>
<td>20 mg twice daily</td>
</tr>
<tr>
<td>15 mg twice daily</td>
<td>15 mg twice daily</td>
</tr>
<tr>
<td>10 mg twice daily</td>
<td>10 mg twice daily</td>
</tr>
<tr>
<td>5 mg twice daily</td>
<td>5 mg twice daily</td>
</tr>
<tr>
<td>Less than 50 X 10^9/L</td>
<td>Hold</td>
</tr>
</tbody>
</table>

2.1.2 Dose Modification Based on Insufficient Response for Patients with Myelofibrosis Starting Treatment with a Platelet Count of 100 X 10^9/L or Greater

If the response is insufficient and platelet and neutrophil counts are adequate, doses may be increased in 5 mg twice daily increments to a maximum of 25 mg twice daily.

Doses should not be increased during the first 4 weeks of therapy and not more frequently than every 2 weeks.

Consider dose increases in patients who meet all of the following conditions:

a. Failure to achieve a reduction from pretreatment baseline in either palpable spleen length of 50% or a 35% reduction in spleen volume as measured by computed tomography (CT) or magnetic resonance imaging (MRI);

b. Platelet count greater than 125 x 10^9/L at 4 weeks and platelet count never below 100 x 10^9/L;

c. ANC levels greater than 0.75 x 10^9/L.

Based on limited clinical data, long-term maintenance at a 5 mg twice daily dose has not shown responses and continued use at this dose should be limited to patients in whom the benefits outweigh the potential risks. Discontinue Jakafi if there is no spleen size reduction or symptom improvement after 6 months of therapy.

2.1.3 Dose Modifications for Hematologic Toxiciy for Patients with Myelofibrosis Starting Treatment with Platelet Counts of 50 X 10^9/L to Less Than 100 X 10^9/L

This section applies only to patients with platelet counts of 50 X 10^9/L to less than 100 X 10^9/L prior to any treatment with Jakafi. See Section 2.1.1 for dose modifications for hematological toxicity in patients whose platelet counts were 100 X 10^9/L or more prior to starting treatment with Jakafi.

Treatment Interruption and Restarting Dosing

Interrupt treatment for platelet counts less than 25 X 10^9/L or ANC less than 0.5 X 10^9/L.

After recovery of platelet counts above 35 X 10^9/L and ANC above 0.75 X 10^9/L, dosing may be restarted. Restart dosing at the higher of 5 mg once daily or 5 mg twice daily below the largest dose in the week prior to the decrease in platelet count below 25 X 10^9/L or ANC below 0.5 X 10^9/L that led to dose interruption.

Dose Reductions

Reduce the dose of Jakafi for platelet counts less than 35 X 10^9/L as described in Table 4.

Table 4:  Myelofibrosis: Dosing Modifications for Thrombocytopenia for Patients with Starting Platelet Count of 50 X 10^9/L to Less Than 100 X 10^9/L

<table>
<thead>
<tr>
<th>Platelet Count</th>
<th>Dosing Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 25 X 10^9/L</td>
<td>• Interrupt dosing.</td>
</tr>
<tr>
<td>25 X 10^9/L to less than 35 X 10^9/L AND the platelet count decline is less than 20% during the prior four weeks</td>
<td>• Decrease dose by 5 mg once daily.</td>
</tr>
<tr>
<td>25 X 10^9/L to less than 35 X 10^9/L AND the platelet count decline is 20% or greater during the prior four weeks</td>
<td>• For patients on 5 mg once daily, maintain dose at 5 mg once daily.</td>
</tr>
</tbody>
</table>

2.1.4 Dose Modifications Based on Insufficient Response for Patients with Myelofibrosis and Starting Platelet Count of 50 X 10^9/L to Less Than 100 X 10^9/L

Do not increase doses during the first 4 weeks of therapy, and do not increase the dose more frequently than every 2 weeks.

If the response is insufficient as defined in Section 2.1.2, doses may be increased by increments of 5 mg daily to a maximum of 10 mg twice daily.

a. the platelet count has remained at least 40 X 10^9/L, and

b. the platelet count has not fallen by more than 20% in the prior 4 weeks, and

c. the ANC is more than 1 X 10^9/L, and

d. the dose has not been reduced or interrupted for an adverse event or hematological toxicity in the prior 4 weeks.

Continuation of treatment for more than 6 months should be limited to patients in whom the benefits outweigh the potential risks. Discontinue Jakafi if there is no spleen size reduction or symptom improvement after 6 months of therapy.

2.1.5 Dose Modification for Bleeding

Interrupt treatment for bleeding requiring intervention regardless of current platelet count. Once the bleeding event has resolved, consider resuming treatment at the prior dose if the underlying cause of bleeding has been controlled. If the bleeding event has resolved but the underlying cause persists, consider resuming treatment with Jakafi at a lower dose.
2.2 Polycythemia Vera

The recommended starting dose of Jakafi is 10 mg twice daily. Doses may be titrated based on safety and efficacy.

2.2.1 Dose Modification Guidelines for Patients with Polycythemia Vera

A complete blood count (CBC) and platelet count must be performed before initiating therapy, every 2 to 4 weeks until doses are stabilized, and then as clinically indicated [see Warnings and Precautions (5.1)].

Dose Reductions

Dose reductions should be considered for hemoglobin and platelet count decreases as described in Table 5.

Table 5: Polycythemia Vera: Dose Reductions

<table>
<thead>
<tr>
<th>Hemoglobin and/or Platelet Count</th>
<th>Dosing Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin greater than or equal to 12 g/dL AND platelet count greater than or equal to 100 X 10^9/L</td>
<td>No change required.</td>
</tr>
<tr>
<td>Hemoglobin 10 to less than 12 g/dL AND platelet count 75 to less than 100 X 10^9/L</td>
<td>Dose reductions should be considered with the goal of avoiding dose interruptions for anemia and thrombocytopenia.</td>
</tr>
<tr>
<td>Hemoglobin 8 to less than 10 g/dL OR platelet count 50 to less than 75 X 10^9/L</td>
<td>Reduce dose by 5 mg twice daily. For patients on 5 mg twice daily, decrease the dose to 5 mg once daily.</td>
</tr>
<tr>
<td>Hemoglobin less than 8 g/dL OR platelet count less than 50 X 10^9/L</td>
<td>Interrupt dosing.</td>
</tr>
</tbody>
</table>

Treatment Interruption and Restarting Dosing

Interrupt treatment for hemoglobin less than 8 g/dL, platelet counts less than 50 X 10^9/L or ANC less than 1 X 10^9/L. After recovery of the hematologic parameter(s) to acceptable levels, dosing may be restarted. Table 6 illustrates the dose that may be used in restarting Jakafi after a previous interruption.

Table 6: Polycythemia Vera: Restarting Doses for Jakafi after Safety Interruption for Hematologic Parameter(s)

Use the most severe category of a patient’s hemoglobin, platelet count, or ANC abnormality to determine the corresponding maximum restarting dose.

<table>
<thead>
<tr>
<th>Hemoglobin, Platelet Count, or ANC</th>
<th>Maximum Restarting Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin less than 8 g/dL OR platelet count less than 50 X 10^9/L OR ANC less than 1 X 10^9/L</td>
<td>Continue hold</td>
</tr>
<tr>
<td>Hemoglobin 8 to less than 10 g/dL OR platelet count 50 to less than 75 X 10^9/L OR ANC 1 to less than 1.5 X 10^9/L</td>
<td>5 mg twice daily* or no more than 5 mg twice daily less than the dose which resulted in dose interruption</td>
</tr>
<tr>
<td>Hemoglobin 10 to less than 12 g/dL OR platelet count 75 to less than 100 X 10^9/L OR ANC 1.5 to less than 2 X 10^9/L</td>
<td>10 mg twice daily* or no more than 5 mg twice daily less than the dose which resulted in dose interruption</td>
</tr>
<tr>
<td>Hemoglobin greater than or equal to 12 g/dL OR platelet count greater than or equal to 100 X 10^9/L OR ANC greater than or equal to or 2 X 10^9/L</td>
<td>15 mg twice daily* or no more than 5 mg twice daily less than the dose which resulted in dose interruption</td>
</tr>
</tbody>
</table>

* Continue treatment for at least 2 weeks; if stable, may increase dose by 5 mg twice daily.

Patients who had required dose interruption while receiving a dose of 5 mg twice daily, may restart at a dose of 5 mg twice daily or 5 mg once daily, but not higher, once hemoglobin is greater than or equal to 10 g/dL, platelet count is greater than or equal to 75 X 10^9/L, and ANC is greater than or equal to 1.5 X 10^9/L.

Dose Management after Restarting Treatment

After restarting Jakafi following treatment interruption, doses may be titrated, but the maximum total daily dose should not exceed 5 mg less than the dose that resulted in the dose interruption. An exception to this is dose interruption following phlebotomy-associated anemia, in which case the maximum total daily dose allowed after restarting Jakafi would not be limited.

2.2.2 Dose Modifications Based on Insufficient Response for Patients with Polycythemia Vera

If the response is insufficient and platelet, hemoglobin, and neutrophil counts are adequate, doses may be increased in 5 mg twice daily increments to a maximum of 25 mg twice daily.

Doses should not be increased during the first 4 weeks of therapy and not more frequently than every two weeks. Consider dose increases in patients who meet all of the following conditions:

1. Inadequate efficacy as demonstrated by one or more of the following:
   a. Continued need for phlebotomy
   b. WBC greater than the upper limit of normal range
   c. Platelet count greater than the upper limit of normal range
   d. Palpable spleen that is reduced by less than 25% from Baseline

2. Platelet count greater than or equal to 140 X 10^9/L

3. Hemoglobin greater than or equal to 12 g/dL

4. ANC greater than or equal to 1.5 X 10^9/L

2.3 Dose Modifications for Concomitant Use with Strong CYP3A4 Inhibitors or Fluconazole

Modify the Jakafi dosage when coadministered with strong CYP3A4 inhibitors and fluconazole doses of less than or equal to 200 mg [see Drug Interactions (7)], according to Table 7.

Additional dose modifications should be made with frequent monitoring of safety and efficacy. Avoid the use of fluconazole doses of greater than 200 mg daily with Jakafi.

Table 7: Dose Modifications for Concomitant Use with Strong CYP3A4 Inhibitors or Fluconazole

<table>
<thead>
<tr>
<th>For patients coadministered strong CYP3A4 inhibitors or fluconazole doses of less than or equal to 200 mg</th>
<th>Recommended Dose Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting dose for patients with MF with a platelet count:</td>
<td></td>
</tr>
<tr>
<td>• Greater than or equal to 100 X 10^9/L</td>
<td>10 mg twice daily</td>
</tr>
<tr>
<td>• 50 X 10^9/L to less than 100 X 10^9/L</td>
<td>5 mg once daily</td>
</tr>
<tr>
<td>Starting dose for patients with PV:</td>
<td>5 mg twice daily</td>
</tr>
<tr>
<td>If on stable dose for patients with MF and PV:</td>
<td></td>
</tr>
<tr>
<td>• Greater than or equal to 10 mg twice daily</td>
<td>Decrease dose by 50% (round up to the closest available tablet strength)</td>
</tr>
<tr>
<td>• 5 mg twice daily</td>
<td>5 mg once daily</td>
</tr>
<tr>
<td>• 5 mg once daily</td>
<td>Avoid strong CYP3A4 inhibitor or fluconazole treatment or interrupt Jakafi treatment for the duration of strong CYP3A4 inhibitor or fluconazole use</td>
</tr>
</tbody>
</table>

2.4 Dose Modifications for Organ Impairment

Renal Impairment

Patients with Moderate or Severe Renal Impairment

Modify the Jakafi dosage for patients with moderate or severe renal impairment according to Table 8.

Table 8: Dose Modifications for Renal Impairment

<table>
<thead>
<tr>
<th>Renal Impairment Status</th>
<th>Platelet Count</th>
<th>Recommended Starting Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with MF Moderate (CLcr 30 to 59 mL/min) or Severe (CLcr 15 to 29 mL/min)</td>
<td>Greater than 150 X 10^9/L</td>
<td>No dose modification needed</td>
</tr>
<tr>
<td></td>
<td>100 X 10^9/L to 150 X 10^9/L</td>
<td>10 mg twice daily</td>
</tr>
<tr>
<td></td>
<td>50 to less than 100 X 10^9/L</td>
<td>5 mg daily</td>
</tr>
<tr>
<td></td>
<td>Less than 50 X 10^9/L</td>
<td>Avoid use [see Use in Specific Populations (8.6)]</td>
</tr>
<tr>
<td>Patients with PV Moderate (CLcr 30 to 59 mL/min) or Severe (CLcr 15 to 29 mL/min)</td>
<td>Any</td>
<td>5 mg twice daily</td>
</tr>
</tbody>
</table>

Patients with End Stage Renal Disease on Dialysis

The recommended starting dose for patients with MF with end stage renal disease (ESRD) on dialysis is 15 mg once after a dialysis session for patients with a platelet count between 100 X 10^9/L and 200 X 10^9/L or 20 mg once after a dialysis session for patients with a platelet count of greater than 200 X 10^9/L.

The recommended starting dose for patients with PV on ESRD (CLcr less than 15 mL/min) is 10 mg. Make additional dose modifications with frequent monitoring of safety and efficacy. Avoid use of Jakafi in patients with ESRD (CLcr less than 15 mL/min) not requiring dialysis [see Use in Specific Populations (8.6)].
Hepatic Impairment
Modify the Jakafi dosage for patients with hepatic impairment according to Table 9.

Table 9: Dose Modifications for Hepatic Impairment

<table>
<thead>
<tr>
<th>Hepatic Impairment Status</th>
<th>Platelet Count</th>
<th>Recommended Starting Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with MF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild, Moderate, or Severe</td>
<td>Greater than 150 X 10^9/L</td>
<td>No dose modification needed</td>
</tr>
<tr>
<td>(Child-Pugh Class A, B, C)</td>
<td>100 X 10^9/L to 150 X 10^9/L</td>
<td>10 mg twice daily</td>
</tr>
<tr>
<td></td>
<td>50 to less than 100 X 10^9/L</td>
<td>5 mg daily</td>
</tr>
<tr>
<td></td>
<td>Less than 50 X 10^9/L</td>
<td>Avoid use [see Use in Specific Populations (8.7)]</td>
</tr>
<tr>
<td>Patients with PV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild, Moderate, or Severe</td>
<td>Any</td>
<td>5 mg twice daily</td>
</tr>
<tr>
<td>(Child-Pugh Class A, B, C)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.5 Method of Administration
Jakafi is dosed orally and can be administered with or without food.

If a dose is missed, the patient should not take an additional dose, but should take the next usual prescribed dose.

When discontinuing Jakafi therapy for reasons other than thrombocytopenia, gradual tapering of the dose of Jakafi may be considered, for example by 5 mg twice daily each week.

For patients unable to ingest tablets, Jakafi can be administered through a nasogastric tube (8 French or greater) as follows:

- Suspend one tablet in approximately 40 mL of water with stirring for approximately 10 minutes.
- Within 6 hours after the tablet has dispersed, the suspension can be administered through a nasogastric tube using an appropriate syringe.

The tube should be rinsed with approximately 75 mL of water. The effect of tube feeding preparations on Jakafi exposure during administration through a nasogastric tube has not been evaluated.

3. DOSAGE FORMS AND STRENGTHS
5 mg tablets - round and white with “INCY” on one side and “5” on the other.
10 mg tablets - round and white with “INCY” on one side and “10” on the other.
15 mg tablets - oval and white with “INCY” on one side and “15” on the other.
20 mg tablets - capsule-shaped and white with “INCY” on one side and “20” on the other.
25 mg tablets - oval and white with “INCY” on one side and “25” on the other.

4. CONTRAINDICATIONS
None.

5. WARNINGS AND PRECAUTIONS
5.1 Thrombocytopenia, Anemia and Neutropenia
Treatment with Jakafi can cause thrombocytopenia, anemia and neutropenia. [see Dosage and Administration (2.1)].

Manage thrombocytopenia by reducing the dose or temporarily interrupting Jakafi. Platelet transfusions may be necessary [see Dosage and Administration (2.1.1), and Adverse Reactions (6.1)].

Patients developing anemia may require blood transfusions and/or dose modifications of Jakafi. Severe neutropenia (ANC less than 0.5 X 10^9/L) was generally reversible by withholding Jakafi until recovery [see Adverse Reactions (6.1)].

Perform a pre-treatment complete blood count (CBC) and monitor CBCs every 2 to 4 weeks until doses are stabilized, and then as clinically indicated [see Dosage and Administration (2.1.1), and Adverse Reactions (6.1)].

5.2 Risk of Infection
Serious bacterial, mycobacterial, fungal and viral infections have occurred. Delay starting therapy with Jakafi until active serious infections have resolved. Observe patients receiving Jakafi for signs and symptoms of infection and manage promptly.

Tuberculosis
Tuberculosis infection has been reported in patients receiving Jakafi. Observe patients receiving Jakafi for signs and symptoms of active tuberculosis and manage promptly.

Prior to initiating Jakafi, patients should be evaluated for tuberculosis risk factors, and those at higher risk should be tested for latent infection. Risk factors include, but are not limited to, prior residence in or travel to countries with a high prevalence of tuberculosis, close contact with a person with active tuberculosis, and a history of active or latent tuberculosis where an adequate course of treatment cannot be confirmed.

For patients with evidence of active or latent tuberculosis, consult a physician with expertise in the treatment of tuberculosis before starting Jakafi. The decision to continue Jakafi during treatment of active tuberculosis should be based on the overall risk-benefit determination.

Progressive Multifocal Leukoencephalopathy
Progressive multifocal leukoencephalopathy (PML) has occurred with Jakafi treatment. If PML is suspected, stop Jakafi and evaluate.

Herpes Zoster
Advise patients about early signs and symptoms of herpes zoster and to seek treatment as early as possible if suspected [see Adverse Reactions (6.1)].

Hepatitis B
Hepatitis B viral load (HBV-DNA titer) increases, with or without associated elevations in alanine aminotransferase and aspartate aminotransferase, have been reported in patients with chronic HBV infections taking Jakafi. The effect of Jakafi on viral replication in patients with chronic HBV infection is unknown. Patients with chronic HBV infection should be treated and monitored according to clinical guidelines.

5.3 Symptom Exacerbation Following Interruption or Discontinuation of Treatment with Jakafi
Following discontinuation of Jakafi, symptoms from myeloproliferative neoplasms may return to pretreatment levels over a period of approximately one week. Some patients with MF have experienced one or more of the following adverse events after discontinuing Jakafi: fever, respiratory distress, hypotension, DIC, or multi-organ failure. If one or more of these occur after discontinuation of, or while tapering the dose of Jakafi, evaluate for and treat any concurrent illness and consider restarting or increasing the dose of Jakafi. Instruct patients not to interrupt or discontinue Jakafi therapy without consulting their physician. When discontinuing or interrupting therapy with Jakafi for reasons other than thrombocytopenia or neutropenia [see Dosage and Administration (2.5)], consider tapering the dose of Jakafi gradually rather than discontinuing abruptly.

5.4 Non-Melanoma Skin Cancer
Non-melanoma skin cancers including basal cell, squamous cell, and Merkel cell carcinoma have occurred in patients treated with Jakafi. Perform periodic skin examinations.

5.5 Lipid Elevations
Treatment with Jakafi has been associated with increases in lipid parameters including total cholesterol, low-density lipoprotein (LDL) cholesterol, and triglycerides. The effect of these lipid parameter elevations on cardiovascular morbidity and mortality has not been determined in patients treated with Jakafi. Assess lipid parameters approximately 8-12 weeks following initiation of Jakafi therapy. Monitor and treat according to clinical guidelines for the management of hyperlipidemia.

6. ADVERSE REACTIONS
The following serious adverse reactions are discussed in greater detail in other sections of the labeling:

- Thrombocytopenia, Anemia and Neutropenia [see Warnings and Precautions (5.1)]
- Risk of Infection [see Warnings and Precautions (5.2)]
- Symptom Exacerbation Following Interruption or Discontinuation of Treatment with Jakafi [see Warnings and Precautions (5.3)]
- Non-Melanoma Skin Cancer [see Warnings and Precautions (5.4)]

6.1 Clinical Trials Experience in Myelofibrosis
Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

The safety of Jakafi was assessed in 617 patients in six clinical studies with a median duration of follow-up of 10.9 months, including 301 patients with MF in two Phase 3 studies. In these two Phase 3 studies, patients had a median duration of exposure to Jakafi of 9.5 months (range 0.5 to 17 months), with 89% of patients treated for more than 6 months and 25% treated for more than 12 months. One hundred and eleven (111) patients started treatment at 15 mg twice daily and 190 patients started at 20 mg twice daily. In patients starting treatment with 15 mg twice daily (pretreatment platelet counts of 100 to 200 X 10^9/L) and 20 mg twice daily (pretreatment platelet counts greater than 200 X 10^9/L), 65% and 25% of patients, respectively, required a dose reduction below the starting dose within the first 8 weeks of therapy.

In a double-blind, randomized, placebo-controlled study of Jakafi, among the 155 patients treated with Jakafi, the most frequent adverse drug reactions were thrombocytopenia and anemia [see Table 11]. Thrombocytopenia, anemia and neutropenia are dose related effects. The three most frequent non-hematologic adverse reactions were bruising, dizziness and headache [see Table 10].

Discontinuation for adverse events, regardless of causality, was observed in 11% of patients treated with Jakafi and 11% of patients treated with placebo.
Table 10 presents the most common adverse reactions occurring in patients who received Jakafi in the double-blind, placebo-controlled study during randomized treatment.

### Table 10: Myelofibrosis: Adverse Reactions Occurring in Patients on Jakafi in the Double-blind, Placebo-controlled Study During Randomized Treatment

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>Jakafi (N=155)</th>
<th>Placebo (N=151)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Grades (%)</td>
<td>Grade 3 (%)</td>
</tr>
<tr>
<td>Bruising</td>
<td>23</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Dizziness</td>
<td>18</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Headache</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Urinary Tract Infections</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Weight Gain</td>
<td>7</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Flatulence</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Herpes Zoster</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

### Description of Selected Adverse Drug Reactions

**Anemia**

In the two Phase 3 clinical studies, median time to onset of first CTCAE Grade 2 or higher anemia was approximately 6 weeks. One patient (<1%) discontinued treatment because of anemia. In patients receiving Jakafi, mean decreases in hemoglobin reached a nadir of approximately 1.5 to 2.0 g/dL below baseline after 8 to 12 weeks of therapy and then gradually recovered to reach a new steady state that was approximately 1.0 g/dL below baseline. This pattern was observed in patients regardless of whether they had received transfusions during therapy.

In the randomized, placebo-controlled study, 60% of patients treated with Jakafi and 38% of patients receiving placebo received red blood cell transfusions during randomized treatment. Among transfused patients, the median number of units transfused per month was 1.2 in patients treated with Jakafi and 1.7 in placebo-treated patients.

**Thrombocytopenia**

In the two Phase 3 clinical studies, in patients who developed Grade 3 or 4 thrombocytopenia, the median time to onset was approximately 8 weeks. Thrombocytopenia was generally reversible with dose reduction or dose interruption. The median time to recovery of platelet counts above 50 X 10^9/L was 14 days. Platelet transfusions were administered to 5% of patients receiving Jakafi and to 4% of patients receiving control regimens. Discontinuation of treatment because of thrombocytopenia occurred in <1% of patients receiving Jakafi and <1% of patients receiving control regimens. Patients with a platelet count of 100 X 10^9/L to 200 X 10^9/L before starting Jakafi had a higher frequency of Grade 3 or 4 thrombocytopenia compared to patients with a platelet count greater than 200 X 10^9/L (17% versus 7%).

**Neutropenia**

In the two Phase 3 clinical studies, 1% of patients reduced or stopped Jakafi because of neutropenia. Table 11 provides the frequency and severity of clinical hematologic abnormalities reported for patients receiving treatment with Jakafi or placebo in the placebo-controlled study.

### Table 11: Myelofibrosis: Worst Hematology Laboratory Abnormalities in the Placebo-Controlled Study

<table>
<thead>
<tr>
<th>Laboratory Parameter</th>
<th>Jakafi (N=155)</th>
<th>Placebo (N=151)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Grades (%)</td>
<td>Grade 3 (%)</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>70</td>
<td>9</td>
</tr>
<tr>
<td>Anemia</td>
<td>96</td>
<td>34</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>19</td>
<td>5</td>
</tr>
</tbody>
</table>

### Additional Data from the Placebo-controlled Study

25% of patients treated with Jakafi and 7% of patients treated with placebo developed newly occurring or worsening Grade 1 abnormalities in alanine transaminase (ALT). The incidence of greater than or equal to Grade 2 elevations was 2% for Jakafi with 1% Grade 3 and no Grade 4 ALT elevations.

17% of patients treated with Jakafi and 6% of patients treated with placebo developed newly occurring or worsening Grade 1 abnormalities in aspartate transaminase (AST). The incidence of Grade 2 AST elevations was <1% for Jakafi with no Grade 3 or 4 AST elevations.

17% of patients treated with Jakafi and <1% of patients treated with placebo developed newly occurring or worsening Grade 1 elevations in cholesterol. The incidence of Grade 2 cholesterol elevations was <1% for Jakafi with no Grade 3 or 4 cholesterol elevations.

### 6.2 Clinical Trial Experience in Polycythemia Vera

In a randomized, open-label, active-controlled study, 110 patients with PV resistant to or intolerant of hydroxyurea received Jakafi and 111 patients received best available therapy [see Clinical Studies (14.2)]. The most frequent adverse drug reaction was anemia. Table 12 presents the most frequent non-hematologic treatment emergent adverse events occurring up to Week 32.

Discontinuation for adverse events, regardless of causality, was observed in 4% of patients treated with Jakafi.

### Table 12: Polycythemia Vera: Treatment Emergent Adverse Events Occurring in ≥6% of Patients on Jakafi in the Open-label, Active-controlled Study up to Week 32 of Randomized Treatment

<table>
<thead>
<tr>
<th>Adverse Events</th>
<th>Jakafi (N=110)</th>
<th>Best Available Therapy (N=111)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Grades (%)</td>
<td>Grade 3-4 (%)</td>
</tr>
<tr>
<td>Headache</td>
<td>16</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>15</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Dizziness</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Fatigue</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Pruritus</td>
<td>14</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Dyspnea</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>Muscle Spasms</td>
<td>12</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Nasopharyngitis</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Constipation</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Cough</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Edema</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Arthralgia</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Asthenia</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Epistaxis</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Herpes Zoster</td>
<td>6</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Nausea</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>

### Other clinically important treatment emergent adverse events observed in less than 6% of patients treated with Jakafi were:

- Weight gain, hypertension, and urinary tract infections

Clinically relevant laboratory abnormalities are shown in Table 13.

### Table 13: Polycythemia Vera: Selected Laboratory Abnormalities in the Open-label, Active-controlled Study up to Week 32 of Randomized Treatment

<table>
<thead>
<tr>
<th>Laboratory Parameter</th>
<th>Jakafi (N=110)</th>
<th>Best Available Therapy (N=111)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Grades (%)</td>
<td>Grade 3 (%)</td>
</tr>
<tr>
<td>Hematology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td>72</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>27</td>
<td>5</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Chemistry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>35</td>
<td>0</td>
</tr>
<tr>
<td>Elevated ALT</td>
<td>25</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Elevated AST</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>Hypertiglyceridemia</td>
<td>15</td>
<td>0</td>
</tr>
</tbody>
</table>

* Presented values are worst Grade values regardless of baseline

- Indicates laboratory abnormality above or equal to Grade 1
7. DRUG INTERACTIONS

Fluconazole
Concomitant administration of Jakafi with fluconazole doses greater than 200 mg daily may increase ruxolitinib exposure due to inhibition of both the CYP3A4 and CYP2C9 metabolic pathways [see Clinical Pharmacology (12.3)]. Increased exposure may increase the risk of exposure-related adverse reactions. Avoid the concomitant use of Jakafi with fluconazole doses of greater than 200 mg daily [see Dosage and Administration (2.3)].

Strong CYP3A4 inhibitors
Concomitant administration of Jakafi with strong CYP3A4 inhibitors increases ruxolitinib exposure [see Clinical Pharmacology (12.3)]. Increased exposure may increase the risk of exposure-related adverse reactions. Consider dose reduction when administering Jakafi with strong CYP3A4 inhibitors [see Dosage and Administration (2.3)].

Strong CYP3A4 inducers
Concomitant administration of Jakafi with strong CYP3A4 inducers may decrease ruxolitinib exposure [see Clinical Pharmacology (12.3)]. No dose adjustment is recommended; however, monitor patients frequently and adjust the Jakafi dose based on safety and efficacy [see Clinical Pharmacology (12.3)].

8. USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary
When pregnant rats and rabbits were administered ruxolitinib during the period of organogenesis adverse developmental outcomes occurred at doses associated with maternal toxicity (see Data). There are no studies with the use of Jakafi in pregnant women to inform drug-associated risks.

The background risk of major birth defects and miscarriage for the indicated populations is unknown. Adverse outcomes in pregnancy occur regardless of the health of the mother or the use of medications. The background risk in the U.S. general population of major birth defects is 2% to 4% and miscarriage is 15% to 20% of clinically recognized pregnancies.

Data
Animal Data
Ruxolitinib was administered orally to pregnant rats or rabbits during the period of organogenesis, at doses of 15, 30, or 60 mg/kg/day in rats and 10, 30, or 60 mg/kg/day in rabbits. There were no treatment-related malformations. Adverse developmental outcomes, such as decreases of approximately 9% in fetal weights were noted in rats at the highest and maternally toxic dose of 60 mg/kg/day. This dose results in an exposure (AUC) that is approximately 2 times the clinical exposure at the maximum recommended dose of 25 mg twice daily. In rabbits, lower fetal weights of approximately 8% and increased late resorptions were noted at the highest and maternally toxic dose of 60 mg/kg/day. This dose is approximately 7% the clinical exposure at the maximum recommended dose.

In a pre- and post-natal development study in rats, pregnant animals were dosed with ruxolitinib from implantation through lactation at doses up to 30 mg/kg/day. There were no drug-related adverse findings in pups for fertility indices or for maternal or embryofetal survival, growth and development parameters at the highest dose evaluated (34% the clinical exposure at the maximum recommended dose of 25 mg twice daily).

8.2 Lactation

Risk Summary
No data are available regarding the presence of ruxolitinib in human milk, the effects on the breast fed infant, or the effects on milk production. Ruxolitinib and/or its metabolites were present in the milk of lactating rats (see Data). Because many drugs are present in human milk and because of the potential for thrombocytopenia and anemia shown for Jakafi in human studies, discontinue breastfeeding during treatment with Jakafi and for two weeks after the final dose.

Data
Animal Data
Lactating rats were administered a single dose of [14C]-labeled ruxolitinib (30 mg/kg) on postnatal Day 10, after which plasma and milk samples were collected for up to 24 hours. The AUC for total radioactivity in milk was approximately 13-fold the maternal plasma AUC. Additional analysis showed the presence of ruxolitinib and several of its metabolites in milk, all at levels higher than those in maternal plasma.

8.4 Pediatric Use

The safety and effectiveness of Jakafi in pediatric patients have not been established.

Jakafi was evaluated in a single-arm, dose-escalation study (NCT01164163) in 27 pediatric patients with relapsed or refractory solid tumors (Cohort A) and 20 with leukemias or myeloproliferative neoplasms (Cohort B). The patients had a median age of 14 years (range, 2 to 21 years) and included 18 children (age 2 to < 12 years), and 14 adolescents (age 12 to < 17 years). The dose levels tested were 15, 21, 29, 39, or 50 mg/m² twice daily in 28-day cycles with up to 6 patients per dose group.

Overall, 38 (81%) patients were treated with no more than a single cycle of Jakafi, while 3, 1, 2, and 3 patients received 2, 3, 4, and 5 or more cycles, respectively. A protocol-defined maximal tolerated dose was not observed, but since few patients were treated for multiple cycles, tolerability with continued use was not assessed adequately to establish a recommended Phase 2 dose. The safety profile in children was similar to that seen in adult patients.
Cardiac Electrophysiology
At a dose of 1.25 to 10 times the highest recommended starting dosage, Jakafi does not prolong the QT interval to any clinically relevant extent.

12.3 Pharmacokinetics
Mean ruxolitinib maximal plasma concentration (Cmax) and AUC increased proportionally over a single dose range of 5 mg to 200 mg. Mean Cmax and Cmax ranged from 205 nm to 7100 nm and AUC ranged from 862 nm to 30700 nm over a single dose range of 5 mg to 200 mg.

Absorption
Ruxolitinib achieves Cmax within 1 hour to 2 hours post-dose. Oral absorption of ruxolitinib is estimated to be at least 95%.

Food Effect
No clinically relevant changes in the pharmacokinetics of ruxolitinib were observed upon administration of Jakafi with a high-fat, high-calorie meal (approximately 800 to 1000 calories of which 50% were derived from fat).

Distribution
The mean volume of distribution at steady-state is 72 L (coefficient of variation [CV] 29%) in patients with MF and 75 L (23%) in patients with PV.

Binding to plasma proteins is approximately 97%, mostly to albumin.

Elimination
The mean elimination half-life of ruxolitinib is approximately 3 hours and the mean half-life of ruxolitinib metabolites is approximately 5.8 hours.

Ruxolitinib clearance was 17.7 L/h in women and 22.1 L/h in men with PV (39% inter-subject variability).

Ruxolitinib clearance was 12.7 L/h in patients with PV (42% inter-subject variability).

Metabolism
Ruxolitinib is metabolized by CYP3A4 and to a lesser extent by CYP2C9.

Excretion
Following a single oral dose of radiolabeled ruxolitinib, elimination was predominately through metabolism with 74% of radioactivity excreted in urine and 22% excretion via feces. Unchanged drug accounted for less than 1% of the excreted total radioactivity.

Specific Populations
No clinically relevant differences in ruxolitinib pharmacokinetics were observed with regard to age, race, sex, or weight.

Patients with Renal Impairment
The safety and pharmacokinetics of single dose Jakafi (25 mg) were evaluated in a study in healthy subjects [CLCR 72 ml/min to 164 ml/min as estimated using Cockcroft-Gault] and in subjects with mild [CLR 53 ml/min to 83 ml/min], moderate [CLR 38 ml/min to 57 ml/min], or severe renal impairment [CLR 15 ml/min to 51 ml/min]. Additional subjects with ESRD requiring hemodialysis were also enrolled.

The pharmacokinetics of ruxolitinib was similar in subjects with various degrees of renal impairment and in those with normal renal function, but the plasma AUC values of ruxolitinib metabolites increased with increasing severity of renal impairment. This was most marked in the patients with ESRD requiring hemodialysis. The change in the pharmacodynamic marker, pS3AT3 inhibition, was consistent with the corresponding increase in metabolite exposure. Ruxolitinib is not removed by dialysis; however, the removal of some active metabolites by dialysis cannot be ruled out.

Patients with Hepatic Impairment
The safety and pharmacokinetics of single dose Jakafi (25 mg) were evaluated in a study in healthy subjects and in subjects with mild [Child-Pugh A], moderate [Child-Pugh B], and severe hepatic impairment [Child-Pugh C]. The mean AUC for ruxolitinib was increased by 87% in patients with mild impairment, 28% in patients with moderate impairment and 65% in patients with severe hepatic impairment compared to patients with normal hepatic function. The terminal elimination half-life was prolonged in patients with hepatic impairment compared to healthy subjects (4.1 hours to 5 hours versus 2.8 hours). The change in the pharmacodynamic marker, pS3AT3 inhibition, was consistent with the corresponding increase in ruxolitinib exposure except in the severe hepatic impairment cohort where the pharmacodynamic activity was more prolonged in some subjects than expected based on plasma concentrations of ruxolitinib.

Drug Interactions
Fluconazole
Simulations suggest that fluconazole (a dual CYP3A4 and CYP2C9 inhibitor) increases steady state ruxolitinib AUC by approximately 100% to 300% following concomitant administration of 10 mg of Jakafi twice daily with 100 mg to 400 mg of fluconazole once daily [see Dosage and Administration (2.3) and Drug Interactions (7)].

Strong CYP3A4 Inhibitors
Ketoconazole (a strong CYP3A4 inhibitor) increased ruxolitinib Cmax by 33% and AUC by 91%. Ketoconazole also prolonged ruxolitinib half-life from 3.7 hours to 6 hours [see Dosage and Administration (2.3) and Drug Interactions (7)].

Moderate CYP3A4 Inhibitors
Erythromycin (a moderate CYP3A4 inhibitor) increased ruxolitinib Cmax by 8% and AUC by 27% [see Drug Interactions (7)].

Strong CYP3A4 inducers
Rifampin (a strong CYP3A4 inducer) decreased ruxolitinib Cmax by 32% and AUC by 61%. The relative exposure to ruxolitinib’s active metabolites increased approximately 100% [see Drug Interactions (7)].
Study 1 and 2 Efficacy Results
Efficacy analyses of the primary endpoint in Studies 1 and 2 are presented in Table 14 below. A significantly larger proportion of patients in the Jakafi group achieved a 35% or greater reduction in spleen volume from baseline in both studies compared to placebo in Study 1 and best available therapy in Study 2. A similar proportion of patients in the Jakafi group achieved a 50% or greater reduction in palpable spleen length.

<table>
<thead>
<tr>
<th>Time Points</th>
<th>Study 1</th>
<th>Study 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jakafi (N=155)</td>
<td>Placebo (N=154)</td>
</tr>
<tr>
<td>Number (%) of Patients with Spleen Volume Reduction by 35% or More</td>
<td>65 (42)</td>
<td>1 (&lt;1)</td>
</tr>
<tr>
<td>P-value</td>
<td>&lt; 0.0001</td>
<td>&lt; 0.0001</td>
</tr>
</tbody>
</table>

Figure 1 shows the percent change from baseline in spleen volume for each patient at Week 24 (Jakafi N=139, placebo N=106) or the last evaluation prior to Week 24 for patients who did not complete 24 weeks of randomized treatment (Jakafi N=16, placebo N=47). One (1) patient (placebo) with a missing baseline spleen volume is not included.

Figure 1: Percent Change from Baseline in Spleen Volume at Week 24 in Study 1 and at Week 48 in Study 2 (Intent to Treat)

In Study 1, MF symptoms were a secondary endpoint and were measured using the modified Myelofibrosis Symptom Assessment Form (MFSAF) v2.0 diary. The modified MFSAF is a daily diary capturing the core symptoms of MF (abdominal discomfort, pain under left ribs, night sweats, itching, bone/muscle pain and early satiety). Symptom scores ranged from 0 to 10 with 0 representing symptoms “absent” and 10 representing “worst imaginable” symptoms. These scores were added to create the daily total score, which has a maximum of 60.

Table 15 presents assessments of Total Symptom Score from baseline to Week 24 in Study 1 including the proportion of patients with at least a 50% reduction (ie, improvement in symptoms). At baseline, the mean Total Symptom Score was 18.0 in the Jakafi group and 16.5 in the placebo group. A higher proportion of patients in the Jakafi group had a 50% or greater reduction in Total Symptom Score than in the placebo group, with a median time to response of less than 4 weeks.

Table 15: Improvement in Total Symptom Score in Patients with Myelofibrosis

<table>
<thead>
<tr>
<th>Study 1</th>
<th>Study 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (%) of Patients with 50% or Greater Reduction in Total Symptom Score by Week 24</td>
<td>Jakafi (N=148)</td>
</tr>
<tr>
<td>Jakafi</td>
<td>68 (46)</td>
</tr>
<tr>
<td>P-value</td>
<td>&lt; 0.0001</td>
</tr>
</tbody>
</table>

Figure 2 shows the percent change from baseline in Total Symptom Score for each patient at Week 24 (Jakafi N=129, placebo N=103) or at the last evaluation on randomized therapy prior to Week 24 for patients who did not complete 24 weeks of randomized treatment (Jakafi N=16, placebo N=42). Results are excluded for 5 patients with a baseline Total Symptom Score of zero, 8 patients with missing baseline and 6 patients with insufficient post-baseline data.

Figure 2: Percent Change from Baseline in Total Symptom Score at Week 24 or Last Observation for Each Patient (Study 1)

Figure 3 displays the proportion of patients with at least a 50% improvement in each of the individual symptoms that comprise the Total Symptom Score indicating that all 6 of the symptoms contributed to the higher Total Symptom Score response rate in the group treated with Jakafi.

Figure 3: Proportion of Patients with Myelofibrosis Achieving 50% or Greater Reduction in Individual Symptoms Scores at Week 24

Table 15: Percent of Patients with Myelofibrosis Achieving 35% or Greater Reduction from Baseline in Spleen Volume at Week 24 in Study 1 and at Week 48 in Study 2 (Intent to Treat)

<table>
<thead>
<tr>
<th>Time Points</th>
<th>Study 1</th>
<th>Study 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jakafi (N=138)</td>
<td>Placebo (N=106)</td>
</tr>
<tr>
<td>Number (%) of Patients with Spleen Volume Reduction by 35% or More</td>
<td>65 (42)</td>
<td>1 (&lt;1)</td>
</tr>
<tr>
<td>P-value</td>
<td>&lt; 0.0001</td>
<td>&lt; 0.0001</td>
</tr>
</tbody>
</table>

An exploratory analysis of patients receiving Jakafi also showed improvement in fatigue-related symptoms (ie., tiredness, exhaustion, mental tiredness, and lack of energy) and associated impacts on daily activities (ie., activity limitations related to work, self-care, and exercise) as measured by the PROMIS® Fatigue 7-item short form total score at Week 24. Patients who achieved a reduction of 4.5 points or more from baseline to Week 24 in the PROMIS® Fatigue total score were considered to have achieved a fatigue response. Fatigue response was reported in 35% of patients in the Jakafi group versus 14% of the patients in the placebo group.

Overall survival was a secondary endpoint in both Study 1 and Study 2. Patients in the control groups were eligible for crossover in both studies, and the median times to crossover were 9 months in Study 1 and 17 months in Study 2.

Figure 4 and Figure 5 show Kaplan-Meier curves of overall survival at prospectively planned analyses after all patients remaining on study had completed 144 weeks on study.
14.2 Polycythemia Vera

Study 3 (NCT01243944) was a randomized, open-label, active-controlled Phase 3 study conducted in 222 patients with PV. Patients had been diagnosed with PV for at least 24 weeks, had an inadequate response to or were intolerant of hydroxyurea, required phlebotomy and exhibited splenomegaly. All patients were required to demonstrate hematocrit control between 40-45% prior to randomization. The age ranged from 33 to 90 years with 30% of patients over 65 years of age and 66% were male. Patients had a median spleen volume as measured by MRI or CT of 1272 cm³ (range 254 cm³ to 5147 cm³) and median palpable spleen length below the costal margin was 7 cm.

Patients were randomized to Jakafi or best available therapy. The starting dose of Jakafi was 10 mg twice daily. Doses were then individualized based upon tolerability and efficacy with a maximum dose of 25 mg twice daily. At Week 32, 98 patients were still on Jakafi with 8% receiving greater than 20 mg twice daily, 15% receiving 20 mg twice daily, 33% receiving 15 mg twice daily, 34% receiving 10 mg twice daily, 10% receiving less than 10 mg twice daily. Best available therapy (BAT) was selected by the investigator on a patient-by-patient basis and included hydroxyurea (60%), interferon/pegylated interferon (12%), anagrelide (7%), busulfan (3%), lenalidomide/thalidomide (5%), and observation (15%).

The primary endpoint was the proportion of subjects achieving a response at Week 32, with response defined as achieving both hematocrit control (the absence of phlebotomy eligibility beginning at the Week 8 visit and continuing through Week 32) and spleen volume reduction (a greater than or equal to 35% reduction from baseline in spleen volume at Week 32). Phlebotomy eligibility was defined as a confirmed hematocrit greater than 45% that is at least 3 percentage points higher than the hematocrit obtained at baseline or a confirmed hematocrit greater than 48%, whichever was lower. Secondary endpoints included the proportion of all randomized subjects who achieved the primary endpoint and who maintained their response 48 weeks after randomization. A significantly larger proportion of patients on the Jakafi arm compared to best available therapy also achieved complete hematological remission at Week 32.

### Table 16: Percent of Patients with Polycythemia Vera Achieving the Primary and Key Secondary Endpoints in Study 3 (Intent to Treat)

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>Jakafi (N=110)</th>
<th>Best Available Therapy (N=112)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (% of Patients achieving a Primary Response at Week 32)</td>
<td>25 (23%)</td>
<td>1 (&lt;1%)</td>
</tr>
<tr>
<td>95% CI of the response rate (%)</td>
<td>(15%, 32%)</td>
<td>(0%, 5%)</td>
</tr>
<tr>
<td>P-value</td>
<td>&lt; 0.0001</td>
<td></td>
</tr>
<tr>
<td>Number (% of Patients achieving a Durable Primary Response at Week 48)</td>
<td>22 (20%)</td>
<td>1 (&lt;1%)</td>
</tr>
<tr>
<td>95% CI of the response rate (%)</td>
<td>(13%, 29%)</td>
<td>(0%, 5%)</td>
</tr>
<tr>
<td>P-value</td>
<td>&lt; 0.0001</td>
<td></td>
</tr>
<tr>
<td>Number (% of Patients achieving Complete Hematological Remission at Week 32)</td>
<td>26 (24%)</td>
<td>9 (8%)</td>
</tr>
<tr>
<td>95% CI of the response rate (%)</td>
<td>(16%, 33%)</td>
<td>(4%, 15%)</td>
</tr>
<tr>
<td>P-value</td>
<td>0.0016</td>
<td></td>
</tr>
</tbody>
</table>

In an assessment of the individual components that make up the primary endpoint, there were 66 (60%) patients with hematocrit control on the Jakafi arm vs. 21 (19%) patients on best available therapy at Week 32; 51 (77% of hematocrit responders) patients on the Jakafi arm maintained hematocrit control through Week 80. There were 44 (40%) patients with spleen volume reduction from baseline greater than or equal to 35% on the Jakafi arm vs. 1 (<1%) patient on best available therapy at Week 32; 43 (98% of spleen volume reduction responders) patients on the Jakafi arm maintained spleen volume reduction through Week 80.

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16. HOW SUPPLIED/STORAGE AND HANDLING

Jakafi (ruxolitinib) Tablets are available as follows:

#### Jakafi Trade Presentations

<table>
<thead>
<tr>
<th>NDC Number</th>
<th>Strength</th>
<th>Description</th>
<th>Tablets per Bottle</th>
</tr>
</thead>
<tbody>
<tr>
<td>50881-005-60</td>
<td>5 mg</td>
<td>Round tablet with “INCY” on one side and “S” on the other</td>
<td>60</td>
</tr>
<tr>
<td>50881-010-60</td>
<td>10 mg</td>
<td>Round tablet with “INCY” on one side and “10” on the other</td>
<td>60</td>
</tr>
<tr>
<td>50881-015-60</td>
<td>15 mg</td>
<td>Oval tablet with “INCY” on one side and “15” on the other</td>
<td>60</td>
</tr>
<tr>
<td>50881-020-60</td>
<td>20 mg</td>
<td>Capsule shaped tablet with “INCY” on one side and “20” on the other</td>
<td>60</td>
</tr>
<tr>
<td>50881-025-60</td>
<td>25 mg</td>
<td>Oval tablet with “INCY” on one side and “25” on the other</td>
<td>60</td>
</tr>
</tbody>
</table>

Store at room temperature 20°C to 25°C (68°F to 77°F); excursions permitted between 15°C and 30°C (59°F and 86°F) (see USP Controlled Room Temperature).

17. PATIENT COUNSELING INFORMATION

See FDA-approved patient labeling (Patient Information).

Discuss the following with patients prior to and during treatment with Jakafi:

**Thrombocytopenia, Anemia and Neutropenia**

Inform patients that Jakafi is associated with thrombocytopenia, anemia and neutropenia, and of the need to monitor complete blood counts before and during treatment. Advise patients to observe for and report bleeding.

**Infections**

Inform patients of the signs and symptoms of infection and to report any such signs and symptoms promptly.
Inform patients regarding the early signs and symptoms of herpes zoster and of progressive multifocal leukoencephalopathy, and advise patients to seek advice of a clinician if such symptoms are observed.

**Symptom Exacerbation Following Interruption or Discontinuation of Treatment with Jakafi**
Inform patients that after discontinuation of treatment, signs and symptoms from myeloproliferative neoplasms are expected to return. Instruct patients not to interrupt or discontinue Jakafi therapy without consulting their physician.

**Non-Melanoma Skin Cancer**
Inform patients that Jakafi may increase their risk of certain non-melanoma skin cancers. Advise patients to inform their healthcare provider if they have ever had any type of skin cancer or if they observe any new or changing skin lesions.

**Lipid Elevations**
Inform patients that Jakafi may increase blood cholesterol, and of the need to monitor blood cholesterol levels.

**Drug-drug Interactions**
Advise patients to inform their healthcare providers of all medications they are taking, including over-the-counter medications, herbal products and dietary supplements.

**Dialysis**
Inform patients on dialysis that their dose should not be taken before dialysis but only following dialysis.

**Lactation**
Inform women not to breastfeed during treatment with Jakafi and for two weeks after the final dose.

**Compliance**
Advise patients to continue taking Jakafi every day for as long as their physician tells them and that this is a long-term treatment. Patients should not change dose or stop taking Jakafi without first consulting their physician. Patients should be aware that after discontinuation of treatment, signs and symptoms from myeloproliferative neoplasms are expected to return.

Manufactured for:
Incyte Corporation
Wilmington, DE 19803

Jakafi® (ruxolitinib) tablets

Inform patients regarding the early signs and symptoms of herpes zoster and of progressive multifocal leukoencephalopathy, and advise patients to seek advice of a clinician if such symptoms are observed.

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Inform patients that Jakafi may increase blood cholesterol, and of the need to monitor blood cholesterol levels.

**Drug-drug Interactions**
Advise patients to inform their healthcare providers of all medications they are taking, including over-the-counter medications, herbal products and dietary supplements.

**Dialysis**
Inform patients on dialysis that their dose should not be taken before dialysis but only following dialysis.

**Lactation**
Inform women not to breastfeed during treatment with Jakafi and for two weeks after the final dose.

**Compliance**
Advise patients to continue taking Jakafi every day for as long as their physician tells them and that this is a long-term treatment. Patients should not change dose or stop taking Jakafi without first consulting their physician. Patients should be aware that after discontinuation of treatment, signs and symptoms from myeloproliferative neoplasms are expected to return.

Manufactured for:
Incyte Corporation
Wilmington, DE 19803
Patient Information

JAKAFI® (JAK-ah-fye)
(ruxolitinib)
tablets

Read this Patient Information before you start taking Jakafi and each time you get a refill. There may be new information. This information does not take the place of talking to your healthcare provider about your medical condition or treatment.

What is Jakafi?
Jakafi is a prescription medicine used to treat certain types of myelofibrosis.

Jakafi is also used to treat people with polycythemia vera who have already taken a medicine called hydroxyurea and it did not work well enough or they could not tolerate it.

It is not known if Jakafi is safe or effective in children.

What should I tell my healthcare provider before taking Jakafi?
Before taking Jakafi, tell your healthcare provider if you:
- have an infection
- have or had tuberculosis (TB), or have been in close contact with someone who has TB
- have or had hepatitis B
- have or have had liver problems
- have or have had kidney problems or are on dialysis. If you are on dialysis, Jakafi should be taken after your dialysis
- have had skin cancer in the past
- have any other medical conditions
- are pregnant or plan to become pregnant. It is not known if Jakafi will harm your unborn baby.
- are breastfeeding or plan to breastfeed. It is not known if Jakafi passes into your breast milk. You and your healthcare provider should decide if you will take Jakafi or breastfeed. You should not do both.

Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins and herbal supplements. Taking Jakafi with certain other medicines may affect how Jakafi works. Especially tell your healthcare provider if you take medicine for:
- Fungal infections
- Bacterial infections
- HIV-AIDS

Ask your healthcare provider or pharmacist if you are not sure if your medicine is one listed above.

Know the medicines you take. Keep a list of them to show your healthcare provider and pharmacist when you get a new medicine.

How should I take Jakafi?
- Take Jakafi exactly as your healthcare provider tells you.
- Do not change your dose or stop taking Jakafi without first talking to your healthcare provider.
- You can take Jakafi with or without food.
- Jakafi may also be given through certain nasogastric tubes.
  - Tell your healthcare provider if you cannot take Jakafi by mouth. Your healthcare provider will decide if you can take Jakafi through a nasogastric tube.
  - Ask your healthcare provider to give you specific instruction on how to properly take Jakafi through a nasogastric tube.
- Do not drink grapefruit juice while taking Jakafi. Grapefruit juice can affect the amount of Jakafi in your blood.
- If you take too much Jakafi call your healthcare provider or go to the nearest hospital emergency room right away. Take the bottle of Jakafi with you.
- If you miss a dose of Jakafi, take your next dose at your regular time. Do not take 2 doses at the same time.
- You will have regular blood tests during your treatment with Jakafi. Your healthcare provider may change your dose of Jakafi or stop your treatment based on the results of your blood tests.
What are the possible side effects of Jakafi?

Jakafi can cause serious side effects including:

Low blood cell counts. Jakafi may cause low platelet counts (thrombocytopenia), low red blood cell counts (anemia), and low white blood cell counts (neutropenia). If you develop bleeding, stop Jakafi and call your healthcare provider. Your healthcare provider will do a blood test to check your blood cell counts before you start Jakafi and regularly during your treatment with Jakafi. Tell your healthcare provider right away if you develop or have worsening of any of these symptoms:

- unusual bleeding
- bruising
- tiredness
- shortness of breath
- fever

Infection. You may be at risk for developing a serious infection during treatment with Jakafi. Tell your healthcare provider if you develop any of the following symptoms of infection:

- chills
- aches
- fever
- nausea
- vomiting
- weakness
- painful skin rash or blisters

Skin cancers. Some people who take Jakafi have developed certain types of non-melanoma skin cancers. Tell your healthcare provider if you develop any new or changing skin lesions during treatment with Jakafi.

Cholesterol increases. You may have changes in your blood cholesterol levels. Your healthcare provider will do blood tests to check your cholesterol levels during treatment with Jakafi.

The most common side effects of Jakafi include:

- low platelet count (thrombocytopenia)
- low red blood cell counts (anemia)
- bruising
- dizziness
- headache

Tell your healthcare provider about any side effect that bothers you or that does not go away.

These are not all the possible side effects of Jakafi. Ask your healthcare provider or pharmacist for more information.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

How should I store Jakafi?

- Store Jakafi at room temperature from 68°F to 77°F (20°C to 25°C).

Keep Jakafi and all medicines out of the reach of children.

General information about the safe and effective use of Jakafi.

Medicines are sometimes prescribed for purposes other than those listed in Patient Information. Do not use Jakafi for a condition for which it is not prescribed. Do not give Jakafi to other people, even if they have the same symptoms you have. It may harm them.

This Patient Information leaflet summarizes the most important information about Jakafi. If you would like more information, talk with your healthcare provider. You can ask your pharmacist or healthcare provider for information that is written for healthcare professionals.

For more information call 1-855-463-3463 or go to www.jakafi.com.

What are the ingredients in Jakafi?

Active ingredient: ruxolitinib phosphate

Inactive ingredients: microcrystalline cellulose, lactose monohydrate, magnesium stearate, colloidal silicon dioxide, sodium starch glycolate, povidone and hydroxypropyl cellulose

Manufactured for: Incyte Corporation, Wilmington, DE 19803
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U.S. Patent Nos. 7598257; 8415362; 8722693; 8822481; 8829013; 9079912
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