Jakafi®
ruxolitinib (tablets)

In adults with polycythemia vera (PV) who have had an inadequate response to hydroxyurea (HU),[1]

Intervene with Jakafi to achieve durable count control

NCCN GUIDELINES® RECOMMEND ***...ruxolitinib as a treatment option for patients with PV who have had an inadequate response to or are intolerant of cytoreductive therapy[2]***

Indications and Usage

Jakafi is indicated for treatment of polycythemia vera (PV) in adults who have had an inadequate response to or are intolerant of hydroxyurea.

Important safety considerations

- Treatment with Jakafi can cause thrombocytopenia, anemia and neutropenia. 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. In patients with cytopenias, consider dose reductions or temporarily withholding Jakafi or transfusions, as clinically indicated
- Serious bacterial, mycobacterial, fungal and viral infections have occurred. Delay starting Jakafi until active serious infections have resolved. Evaluate patients prior to and while receiving Jakafi for signs and symptoms of infection and manage promptly. Use active surveillance and prophylactic antibiotics according to clinical guidelines

Please see related and other Important Safety Information on pages 12-13. Please click here to see Full Prescribing Information for Jakafi.

Experience with Jakafi since FDA approval[3]*

7+ YEARS MORE THAN **30,000** PATIENTS TREATED

* Estimated total patients treated with commercially available Jakafi in the US since 2011.[3]
See Prescribing Information for FDA-approved indications.

For your adult patients on HU and phlebotomy,

Proactively identify the characteristics of advanced PV and treat differently

In a subset of patients, these characteristics may indicate advanced PV despite treatment with HU at the maximum tolerated dose and phlebotomy[4-8]

Hct ≥45% PLUS **WBC COUNT >11×10⁹/L** OR **Disease-related SYMPTOMS**

Hct, hematocrit; HU, hydroxyurea; PV, polycythemia vera; WBC, white blood cell.

PV *…is a hematologic malignancy that can become advanced in a subset of patients[4,9-13]*

Risk of infection

- Serious bacterial, mycobacterial, fungal and viral infections have occurred. Delay starting Jakafi until active serious infections have resolved. Observe patients receiving Jakafi for signs and symptoms of infection and manage promptly. Use active surveillance and prophylactic antibiotics according to clinical guidelines
- Tuberculosis (TB) infection has been reported. Observe patients taking Jakafi for signs and symptoms of active TB and manage promptly. Prior to initiating Jakafi, evaluate patients for TB risk factors and test those at higher risk for latent infection. Consult a physician with expertise in the treatment of TB before starting Jakafi in patients with evidence of active or latent TB. Continuation of Jakafi during treatment of active TB should be based on the overall risk-benefit determination
- Progressive multifocal leukoencephalopathy (PML) has occurred with Jakafi treatment. If PML is suspected, stop Jakafi and evaluate
- Advise patients about early signs and symptoms of herpes zoster and to seek early treatment
- Increases in hepatitis B viral load with or without associated elevations in alanine aminotransferase and aspartate aminotransferase have been reported in patients with chronic hepatitis B virus (HBV) infections. Monitor and treat patients with chronic HBV infection according to clinical guidelines

Please see related and other Important Safety Information on pages 12-13. Please click here to see Full Prescribing Information for Jakafi.

NCCN Guidelines recommend

Actively monitoring patients' response and signs/symptoms of disease progression

The clinical characteristics of advanced PV are included in the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) as potential indications for change in cytoreductive therapy

NCCN GUIDELINES® RECOMMEND

…actively monitoring[a] patients' response[b] and signs/symptoms of disease progression while on cytoreductive therapy[2]

The presence of *any one* of these factors may warrant a change in cytoreductive therapy

- Intolerance or resistance to HU[14] or interferon
- Leukocytosis
- Disease-related symptoms
- New thrombosis or disease-related major bleeding
- Thrombocytosis
- Frequent and/or persistent need for phlebotomy, but with poor tolerance of phlebotomy
- Splenomegaly

- Jakafi is FDA approved for use in adults with PV after inadequate response to or intolerance of HU[1]
- The phase 3 RESPONSE study defined inadequate response to include the maximum tolerated dose of HU, not just the ELN criteria of 2 g/d, after 3 months[14,15]
- RESPONSE was an open-label trial and, therefore, not designed to evaluate a difference in symptoms[1]
- The clinical effect of Jakafi on thrombosis has not been established

ELN, European LeukemiaNet; HU, hydroxyurea; IWG-MRT, International Working Group-Myeloproliferative Neoplasms Research and Treatment; PV, polycythemia vera.
[a] Every 3-6 months or more frequently as clinically indicated.
[b] Per IWG-MRT and ELN response criteria.

Jakafi® (ruxolitinib) tablets

When PV advances beyond what HU can control, intervene with Jakafi® (ruxolitinib)

In the phase 3 RESPONSE* trial, Jakafi demonstrated superior results† vs BAT[1‡]

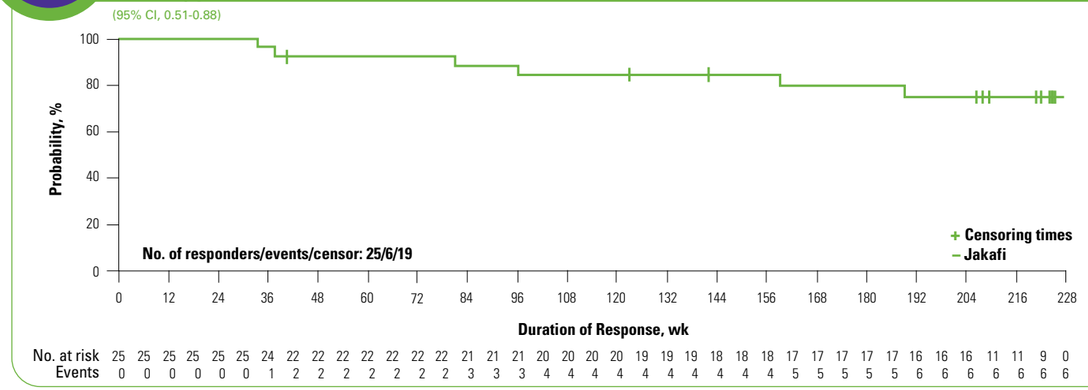
RESPONSE Composite Primary Endpoint

23% **(25/110) of patients receiving Jakafi achieved Hct control and ≥35% spleen volume reduction at week 32 vs <1% (1/112) of patients receiving BAT ($P < 0.0001$)[1§]**

§ Jakafi 95% CI, 0.15-0.32; BAT 95% CI, 0.00-0.05.[1]

Kaplan-Meier Estimate: Durability of Primary Response at 5 years

74% ***Probability of Maintaining the Primary Response at 5 Years[16]***



The median duration of primary response was not reached.

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- Analysis was conducted in week 32 primary responders, beginning at week 32[16]
- Progression was defined as: the first of 2 consecutive Hct assessments that confirmed phlebotomy eligibility, a spleen volume assessment that was reduced by <35% from the baseline AND that was ≥25% increased at the time of the best-documented spleen volume response, death, or development of MF or acute leukemia[3]

66% *72 of 110* ***of patients in the Jakafi arm completed 5 YEARS OF ON-STUDY TREATMENT[16]***

BAT, best available therapy; Hct, hematocrit; HU, hydroxyurea; MF, myelofibrosis.

* The RESPONSE (Randomized study of Efficacy and Safety in POlycythemia vera with JAK iNhibitor ruxolitinib verSus bEst available care) trial was a randomized, open-label, active-controlled phase 3 trial comparing Jakafi with BAT in 222 patients with PV. Patients enrolled in the study had been diagnosed with PV for at least 24 weeks, had an inadequate response to or were intolerant of HU, required phlebotomy for Hct control, and exhibited splenomegaly. All patients were required to demonstrate Hct control between 40% and 45% prior to randomization. After week 32, patients were able to cross over to Jakafi treatment.[1,15]

† The composite primary endpoint was defined as Hct control without phlebotomy eligibility and a ≥35% spleen volume reduction as measured by CT or MRI. To achieve the Hct control endpoint, patients could not become eligible for phlebotomy between weeks 8 and 32. Phlebotomy eligibility was defined as Hct >45% that is ≥3 percentage points higher than baseline or Hct >48% (lower value).[1,15]

‡ BAT included HU (60%), interferon/pegylated interferon (12%), anagrelide (7%), pipobroman (2%), lenalidomide/thalidomide (5%), and observation (15%).[1]

Individual component of the primary endpoint

More patients achieved Hct control with Jakafi

In the RESPONSE trial, Jakafi achieved a higher rate of Hct control vs BAT[1]

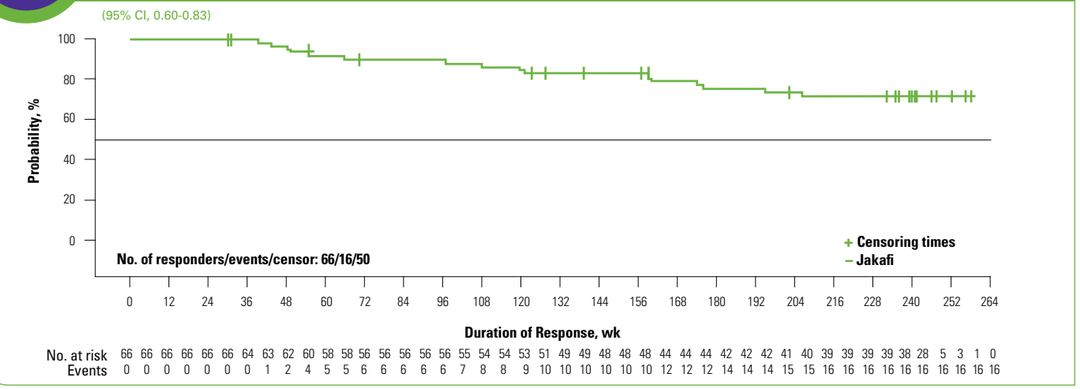
60% **(66/110) of patients receiving Jakafi achieved Hct control at week 32 vs 19% (21/112) of patients receiving BAT[1]**

- To achieve the Hct control endpoint, patients could not become eligible for phlebotomy between weeks 8 and 32. Phlebotomy eligibility was defined as hematocrit >45% that is ≥3 percentage points higher than baseline or Hct >48% (lower value)[1,15]

Kaplan-Meier Estimate: Durability of Hct Control at 5 Years

73% ***Probability of Maintaining Hct Control[a] at 5 Years[16]***

[a]Absence of phlebotomy eligibility



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- Analysis was conducted in week 32 Hct control responders, beginning at week 32[16]
- Progression events for the evaluation of duration of absence of phlebotomy eligibility included first of 2 consecutive Hct assessments that confirms phlebotomy eligibility, death, or development of MF or acute leukemia[3]

BAT, best available therapy; Hct, hematocrit; MF, myelofibrosis.

Risk for thrombocytopenia, anemia, and neutropenia

- Treatment with Jakafi® can cause thrombocytopenia, anemia and neutropenia, which are each dose-related effects. 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
- Manage thrombocytopenia by reducing the dose or temporarily interrupting Jakafi. Platelet transfusions may be necessary
- Patients developing anemia may require blood transfusions and/or dose modifications of Jakafi
- Severe neutropenia (ANC $<0.5 \times 10^9$/L) was generally reversible by withholding Jakafi until recovery

Please see related and other Important Safety Information on pages 12-13. Please click here to see Full Prescribing Information for Jakafi.

Jakafi® ruxolitinib (tablets)

Significantly more patients

Achieved complete hematologic remission with Jakafi® (ruxolitinib)

Jakafi demonstrated significantly higher rates of complete hematologic remission (CHR)* vs BAT[1]

RESPONSE Secondary Endpoint

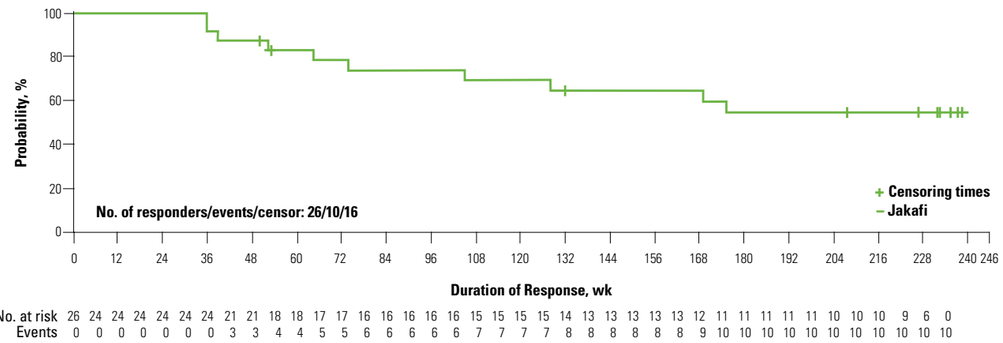
24% (26/110) of patients receiving Jakafi achieved CHR at week 32 vs 8% (9/112) of patients receiving BAT ($P = 0.0016$)[1†]

† Jakafi 95% CI, 0.16-0.33; BAT 95% CI, 0.04-0.15.[1]

Kaplan-Meier Estimate: Durability of CHR at 5 Years

55% ***Probability of Maintaining CHR at 5 Years[16]***

(95% CI, 0.32-0.73)



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- Analysis was conducted in week 32 CHR responders, beginning at week 32[16]
- Progression events for the evaluation of duration of CHR included first of 2 consecutive Hct assessments that confirms phlebotomy eligibility, first of 2 contiguous visits where platelet count >400 × 10^9/L or WBC count >10 × 10^9/L, death, or development of MF or acute leukemia[3]

BAT, best available therapy; MF, myelofibrosis; WBC, white blood cell.
*Complete hematologic remission was defined as achieving hematocrit control (as specified in the primary endpoint), platelet count ≤400 × 10^9/L, and WBC count ≤10 × 10^9/L.[1,15]

Risk for symptom exacerbation following interruption or discontinuation of Jakafi

- When discontinuing Jakafi, myeloproliferative neoplasm-related symptoms may return within one week
- After discontinuation, some patients with myelofibrosis have experienced fever, respiratory distress, hypotension, DIC, or multi-organ failure. If any of these occur after discontinuation or while tapering Jakafi, evaluate and treat any intercurrent illness and consider restarting or increasing the dose of Jakafi
- Instruct patients not to interrupt or discontinue Jakafi without consulting their physician
- When discontinuing or interrupting Jakafi for reasons other than thrombocytopenia or neutropenia, consider gradual tapering rather than abrupt discontinuation

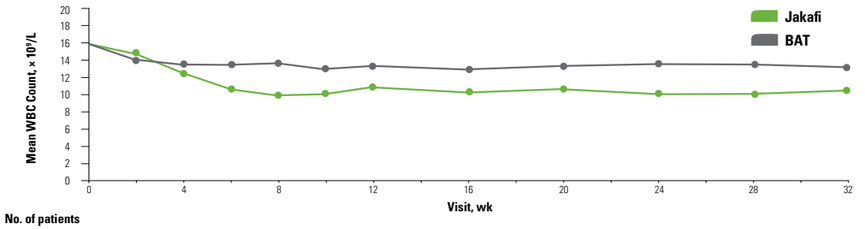
Please see related and other Important Safety Information on pages 12-13. Please click here to see Full Prescribing Information for Jakafi.

Individual components of complete hematologic remission

Jakafi reduced mean WBC and platelet counts

Exploratory Analyses From the RESPONSE Trial: WBC Count Data

Mean WBC Counts Over Time[15]

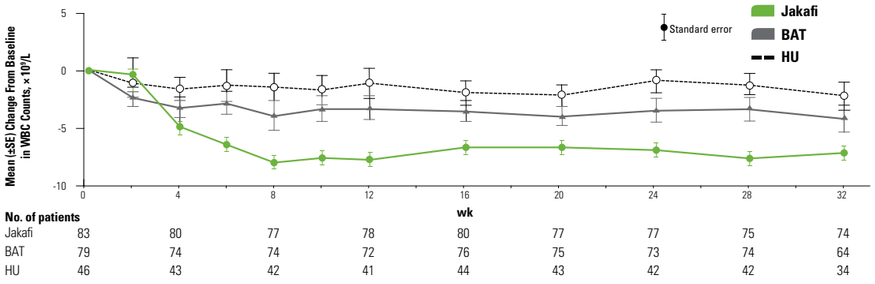


No. of patients					
Jakafi	110	106	103	100	96
BAT	111	107	105	104	87

From *New England Journal of Medicine,* Vannucchi AM, Kiladjian JJ, Griesshammer M, et al, Ruxolitinib versus standard therapy for the treatment of polycythemia vera, 372(5), 426-435. Copyright © 2015 Massachusetts Medical Society. Reprinted with permission from Massachusetts Medical Society.

- As shown below, data for patients treated with HU were included in the group of patients receiving BAT[17]

Mean Change From Baseline in WBC Counts for Patient Subgroups With WBC Counts ≥11 × 10^9/L[17]



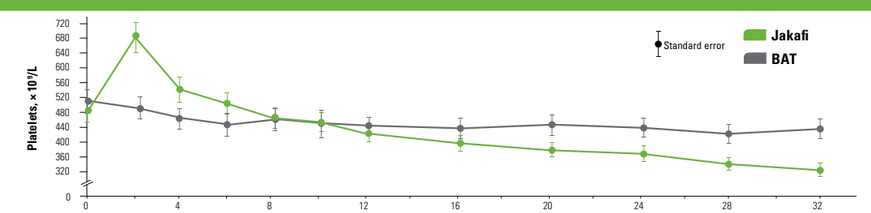
No. of patients									
Jakafi	83	80	77	78	80	77	77	75	74
BAT	79	74	74	72	76	75	73	74	64
HU	46	43	42	41	44	43	42	42	34

Figure reproduced with permission from John Wiley & Sons. Harrison CN, Griesshammer M, Miller C, et al. Comprehensive haematological control with ruxolitinib in patients with polycythaemia vera resistant to or intolerant of hydroxycarbamide. *Br J Haematol.* 2018;182(2):279-284.

- At baseline, 75.5% of patients (n = 83) receiving Jakafi and 71.4% of patients (n = 80) receiving BAT had WBC counts ≥11 × 10^9/L[17]

Exploratory Analysis From the RESPONSE Trial: Platelet Count Data

Mean Platelet Counts Through Week 32[3]



No. of patients									
Jakafi	110	105	106	104	103	102	100	98	96
BAT	111	107	107	106	106	104	104	104	86

BAT, best available therapy; CHR, complete hematologic remission; HU, hydroxyurea; WBC, white blood cell.

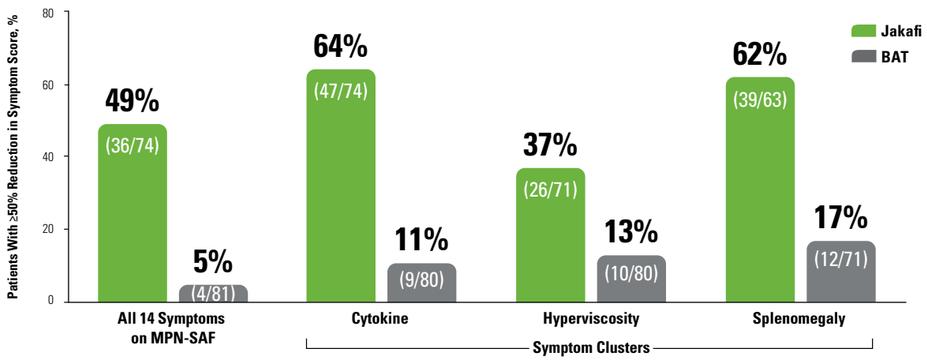
Jakafi® ruxolitinib (tablets)

Jakafi® (ruxolitinib) symptom data

Exploratory endpoint from the RESPONSE trial

- At week 32, 49% of patients receiving Jakafi and 5% of patients receiving BAT had at least a 50% reduction in the 14-item Myeloproliferative Neoplasm Symptom Assessment Form (MPN-SAF) Total Symptom Score[15]
- RESPONSE was an open-label trial and, therefore, not designed to evaluate differences in symptoms[1]
- Patient-reported outcomes were assessed using the MPN-SAF symptom diary. The MPN-SAF diary was administered daily in an electronic diary format to score 14 disease-related symptoms on a scale of 0 (absent) to 10 (worst possible). At baseline, median Total Symptom Score was 23.4 (range, 0-106) in the group receiving Jakafi and 33.3 (range, 0-118) in the group receiving BAT[3,15]

Patients Achieving ≥50% Reduction in MPN-SAF Total Symptom Score at Week 32[15a]



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BAT, best available therapy; MPN-SAF, Myeloproliferative Neoplasm Symptom Assessment Form.

[a] Higher symptom score indicates greater severity of symptoms; cytokine symptom cluster (tiredness, itching, muscle ache, night sweats, and sweating while awake), hyperviscosity symptom cluster (vision problems, dizziness, concentration problems, headache, numbness or tingling in the hands or feet, ringing in the ears, and skin redness), and splenomegaly symptom cluster (abdominal discomfort and early satiety). Patients with data at both baseline (value >0) and week 32 were included in this analysis.[15]

Other important safety considerations

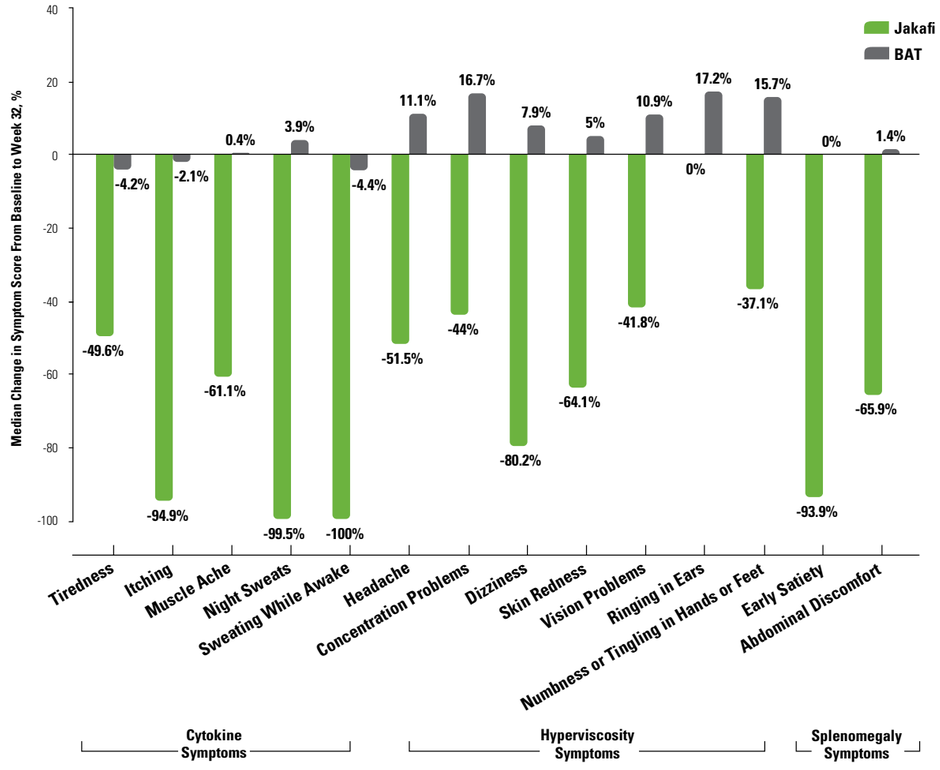
- Non-melanoma skin cancers including basal cell, squamous cell, and Merkel cell carcinoma have occurred. Perform periodic skin examinations
- Treatment with Jakafi has been associated with increases in total cholesterol, low-density lipoprotein cholesterol, and triglycerides. Assess lipid parameters 8-12 weeks after initiating Jakafi. Monitor and treat according to clinical guidelines for the management of hyperlipidemia

Please see related and other Important Safety Information on pages 12-13. Please click here to see Full Prescribing Information for Jakafi.

Exploratory endpoint from the RESPONSE trial

- Patients receiving Jakafi had greater reductions in all symptom clusters reported, whereas patients receiving BAT had an increase in scores of many symptoms[15]

Median Percent Change in Symptom Score From Baseline to Week 32[15a]



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BAT, best available therapy.

[a] Patients with data at both baseline (value >0) and week 32 were included in this analysis. Negative values indicate a reduction in the severity of symptoms.[15]

Jakafi® ruxolitinib (tablets)

Safety profile for Jakafi® (ruxolitinib) in PV

RESPONSE nonhematologic adverse reactions[1,15]

Adverse Reactions (Incidence ≥5%)	Jakafi (n = 110)		BAT (n = 111)	
	All Grades,[a] %	Grades 3 and 4, %	All Grades, %	Grades 3 and 4, %
Diarrhea	15	0	7	<1
Dizziness[b]	15	0	13	0
Dyspnea[c]	13	3	4	0
Muscle spasms	12	<1	5	0
Constipation	8	0	3	0
Herpes zoster[d]	6	<1	0	0
Nausea	6	0	4	0
Weight gain[e]	6	0	<1	0
Urinary tract infections[f]	6	0	3	0
Hypertension	5	<1	3	<1

BAT, best available therapy.
[a] National Cancer Institute Common Terminology Criteria for Adverse Events, version 3.0.
[b] Includes dizziness and vertigo.
[c] Includes dyspnea and dyspnea exertional.
[d] Includes herpes zoster and post-herpetic neuralgia.
[e] Includes weight increased and abnormal weight gain.
[f] Includes urinary tract infection and cystitis.

Clinically relevant laboratory abnormalities[1]

Laboratory Parameter[a]	Jakafi (n = 110)			BAT (n = 111)		
	All Grades,[b] %	Grade 3, %	Grade 4, %	All Grades, %	Grade 3, %	Grade 4, %
Hematology						
Anemia	72	<1	<1	58	0	0
Thrombocytopenia	27	5	<1	24	3	<1
Neutropenia	3	0	<1	10	<1	0
Chemistry						
Hypercholesterolemia	35	0	0	8	0	0
Elevated ALT	25	<1	0	16	0	0
Elevated AST	23	0	0	23	<1	0
Hypertriglyceridemia	15	0	0	13	0	0

ALT, alanine transaminase; AST, aspartate transaminase; BAT, best available therapy.
[a] Presented values are worst grade values regardless of baseline.
[b] National Cancer Institute Common Terminology Criteria for Adverse Events, version 3.0.

- Discontinuation for adverse events, regardless of causality, was observed in 4% of patients treated with Jakafi[1]

Other important safety considerations

- In myelofibrosis and polycythemia vera, the most common nonhematologic adverse reactions (incidence ≥15%) were bruising, dizziness, headache, and diarrhea. In acute graft-versus-host disease, the most common nonhematologic adverse reactions (incidence >50%) were infections and edema

Please see related and other Important Safety Information on pages 12-13. Please click here to see Full Prescribing Information for Jakafi.

Jakafi® ruxolitinib (tablets)

Important Safety Information for Jakafi® (ruxolitinib)

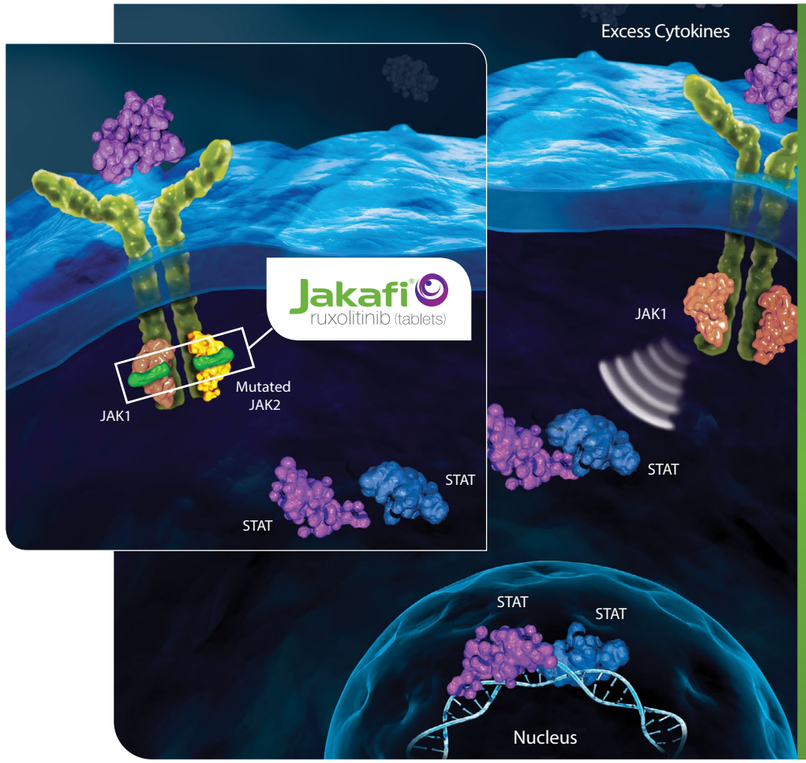
- Treatment with Jakafi® (ruxolitinib) can cause thrombocytopenia, anemia and neutropenia, which are each dose-related effects. Perform a pre-treatment complete blood count (CBC) and monitor CBCs every 2 to 4 weeks until doses are stabilized, and then as clinically indicated
- Manage thrombocytopenia by reducing the dose or temporarily interrupting Jakafi. Platelet transfusions may be necessary
- Patients developing anemia may require blood transfusions and/or dose modifications of Jakafi
- Severe neutropenia (ANC $<0.5 \times 10^9$/L) was generally reversible by withholding Jakafi until recovery
- Serious bacterial, mycobacterial, fungal and viral infections have occurred. Delay starting Jakafi until active serious infections have resolved. Observe patients receiving Jakafi for signs and symptoms of infection and manage promptly. Use active surveillance and prophylactic antibiotics according to clinical guidelines
- Tuberculosis (TB) infection has been reported. Observe patients taking Jakafi for signs and symptoms of active TB and manage promptly. Prior to initiating Jakafi, evaluate patients for TB risk factors and test those at higher risk for latent infection. Consult a physician with expertise in the treatment of TB before starting Jakafi in patients with evidence of active or latent TB. Continuation of Jakafi during treatment of active TB should be based on the overall risk-benefit determination
- Progressive multifocal leukoencephalopathy (PML) has occurred with Jakafi treatment. If PML is suspected, stop Jakafi and evaluate
- Advise patients about early signs and symptoms of herpes zoster and to seek early treatment
- Increases in hepatitis B viral load with or without associated elevations in alanine aminotransferase and aspartate aminotransferase have been reported in patients with chronic hepatitis B virus (HBV) infections. Monitor and treat patients with chronic HBV infection according to clinical guidelines

- When discontinuing Jakafi, myeloproliferative neoplasm-related symptoms may return within one week. After discontinuation, some patients with myelofibrosis have experienced fever, respiratory distress, hypotension, DIC, or multi-organ failure. If any of these occur after discontinuation or while tapering Jakafi, evaluate and treat any intercurrent illness and consider restarting or increasing the dose of Jakafi. Instruct patients not to interrupt or discontinue Jakafi without consulting their physician. When discontinuing or interrupting Jakafi for reasons other than thrombocytopenia or neutropenia, consider gradual tapering rather than abrupt discontinuation
- Non-melanoma skin cancers including basal cell, squamous cell, and Merkel cell carcinoma have occurred. Perform periodic skin examinations
- Treatment with Jakafi has been associated with increases in total cholesterol, low-density lipoprotein cholesterol, and triglycerides. Assess lipid parameters 8-12 weeks after initiating Jakafi. Monitor and treat according to clinical guidelines for the management of hyperlipidemia
- In myelofibrosis and polycythemia vera, the most common nonhematologic adverse reactions (incidence ≥15%) were bruising, dizziness, headache, and diarrhea. In acute graft-versus-host disease, the most common nonhematologic adverse reactions (incidence >50%) were infections and edema
- Dose modifications may be required when administering Jakafi with strong CYP3A4 inhibitors or fluconazole or in patients with renal or hepatic impairment. Patients should be closely monitored and the dose titrated based on safety and efficacy
- Use of Jakafi during pregnancy is not recommended and should only be used if the potential benefit justifies the potential risk to the fetus. Women taking Jakafi should not breastfeed during treatment and for 2 weeks after the final dose

Please click here to see Full Prescribing Information for Jakafi.

Jakafi® ruxolitinib (tablets)

Jakafi® (ruxolitinib) targets the primary driver of PV



JAK1

Plays major role in signaling of key proinflammatory cytokines[18]

JAK2

Mediates signals for hematopoietic growth factors[18]

JAK, Janus-associated kinase; STAT, signal transducer and activator of transcription.

Other important safety considerations

- Dose modifications may be required when administering Jakafi with strong CYP3A4 inhibitors or fluconazole or in patients with renal or hepatic impairment. Patients should be closely monitored and the dose titrated based on safety and efficacy
- Use of Jakafi during pregnancy is not recommended and should only be used if the potential benefit justifies the potential risk to the fetus. Women taking Jakafi should not breastfeed during treatment and for 2 weeks after the final dose

Please see related and other Important Safety Information on pages 12-13. Please click here to see Full Prescribing Information for Jakafi.

Individualized dosing for Jakafi

START 1

For patients with PV who have an inadequate response to HU, the recommended starting dose is 10 mg twice daily. A CBC must be performed before initiating Jakafi[1]

Special Populations

For patients with renal or hepatic impairment or receiving concomitant strong CYP3A4 inhibitors or fluconazole, please refer to the Full Prescribing Information for starting dose, other dose modifications, and when to avoid treatment with Jakafi.[1]

- Avoid fluconazole doses of >200 mg daily with Jakafi[1]
- Avoid use of Jakafi in patients with end-stage renal disease (creatinine clearance, <15 mL/min) not requiring dialysis[1]

MONITOR 2

A CBC must be performed before initiating Jakafi, every 2 to 4 weeks until doses are stabilized, and then as clinically indicated[1]

OPTIMIZE 3

Individualize dosing of Jakafi to optimize balance between safety and efficacy[1]

- Dosing may be reduced or temporarily interrupted based on hemoglobin, platelet, or neutrophil counts[1]
- Additionally, dosing may be increased to achieve desired clinical response[1]
- Interrupt treatment for bleeding[1]
- Refer to the accompanying Full Prescribing Information for Jakafi for details on dose modification[1]

CBC, complete blood count; HU, hydroxyurea; PV, polycythemia vera.

References: 1. Jakafi [package insert]. Wilmington, DE: Incyte Corporation. **2.** Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Myeloproliferative Neoplasms V.3.2019. © National Comprehensive Cancer Network, Inc. 2019. All rights reserved. Accessed September 4, 2019. To view the most recent and complete version of the guideline, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way. **3.** Data on file. Incyte Corporation. Wilmington, DE. **4.** Barosi G, Birgegard G, Finazzi G, et al. A unified definition of clinical resistance and intolerance to hydroxycarbamide in polycythaemia vera and primary myelofibrosis: results of a European LeukemiaNet (ELN) consensus process. *Br J Haematol.* 2010;148(6):961-963. **5.** Marchioli R, Finazzi G, Specchia G, et al; for CYTO-PV Collaborative Group. Cardiovascular events and intensity of treatment in polycythemia vera. *N Engl J Med.* 2013;368(1):22-33. **6.** Barbui T, Masciulli A, Marfisi M, et al. White blood cell counts and thrombosis in polycythemia vera: a subanalysis of the CYTO-PV study. *Blood.* 2015;126(4):560-561. **7.** Emanuel RM, Dueck AC, Geyer HL, et al. Myeloproliferative neoplasm (MPN) symptom assessment form total symptom score: prospective international assessment of an abbreviated symptom burden scoring system among patients with MPNs. *J Clin Oncol.* 2012;30(33):4098-4103. **8.** Verstovsek S, Passamonti F, Rambaldi A, et al. A phase 2 study of ruxolitinib, an oral JAK1 and JAK2 inhibitor, in patients with advanced polycythemia vera who are refractory or intolerant to hydroxyurea. *Cancer.* 2014;120(4):513-520. **9.** Parasuraman S, DiBonaventura M, Reith K, et al. Patterns of hydroxyurea use and clinical outcomes among patients with polycythemia vera in real-world clinical practice: a chart review. *Exp Hematol Oncol.* 2016;5:3. **10.** Mascarenhas J. A concise update on risk factors, therapy, and outcome of leukemic transformation of myeloproliferative neoplasms. *Clin Lymphoma Myeloma Leuk.* 2016;16:S124-S129. **11.** Rumi E, Cazzola M. Diagnosis, risk stratification, and response evaluation in classical myeloproliferative neoplasms. *Blood.* 2017;129(6):680-692. **12.** Michiels JJ, Berneman Z, Schroyens W, et al. PVSG and WHO vs European Clinical, Molecular and Pathological Criteria for prefibrotic myeloproliferative neoplasms. *World J Hematol.* 2013;2(3):71-88. **13.** Michiels JJ. Myeloproliferative and thrombotic burden and treatment outcome of thrombocythemia and polycythemia patients. *World J Crit Care Med.* 2015;4(3):230-239. **14.** Barbui T, Barosi G, Birgegard G, et al. Philadelphia-negative classical myeloproliferative neoplasms: critical concepts and management recommendations from European LeukemiaNet. *J Clin Oncol.* 2011;29(6):761-770. **15.** Vannucchi AM, Kiladjian JJ, Griesshammer M, et al. Ruxolitinib versus standard therapy for the treatment of polycythemia vera. *N Engl J Med.* 2015;372(5):426-435. **16.** Kiladjian J-J, Zachee P, Hino M, et al. Long-term efficacy and safety of ruxolitinib versus best available therapy in polycythaemia vera (RESPONSE): 5-year follow up of a phase 3 study [published online ahead of print January 23, 2020]. *Lancet Haematol.* doi.org/10.1016/S2352-3026(19)30207-8. **17.** Harrison CN, Griesshammer M, Miller C, et al. Comprehensive haematological control with ruxolitinib in patients with polycythaemia vera resistant to or intolerant of hydroxycarbamide. *Br J Haematol.* 2018;182(2):279-284. **18.** Quintás-Cardama A, Vaddi K, Liu P, et al. Preclinical characterization of the selective JAK1/2 inhibitor INCB018424: therapeutic implications for the treatment of myeloproliferative neoplasms. *Blood.* 2010;115(15):3109-3117.

Jakafi® ruxolitinib (tablets)

In adults with PV who have had an inadequate response to HU,[1]

Intervene with Jakafi® (ruxolitinib) to achieve durable count control

PV is a hematologic malignancy that can become advanced in a subset of patients[4,9-13]

Proactively identify the subset of patients with characteristics of advanced PV, despite treatment with HU at the maximum tolerated dose and phlebotomy, and treat differently[4-8]

Hct ≥45% PLUS **WBC COUNT >11×10⁹/L** OR **Disease-related SYMPTOMS**

NCCN GUIDELINES® RECOMMEND

...ruxolitinib as a treatment option for patients with PV who have had an inadequate response to or are intolerant of cytoreductive therapy[2]

Hct, hematocrit; HU, hydroxyurea; WBC, white blood cell.

Indications and Usage

Jakafi is indicated for treatment of polycythemia vera (PV) in adults who have had an inadequate response to or are intolerant of hydroxyurea.

Important safety considerations

- Treatment with Jakafi can cause thrombocytopenia, anemia and neutropenia. 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. In patients with cytopenias, consider dose reductions or temporarily withholding Jakafi or transfusions, as clinically indicated
- Serious bacterial, mycobacterial, fungal and viral infections have occurred. Delay starting Jakafi until active serious infections have resolved. Evaluate patients prior to and while receiving Jakafi for signs and symptoms of infection and manage promptly. Use active surveillance and prophylactic antibiotics according to clinical guidelines

Please see related and other Important Safety Information on pages 12-13. Please click here to see Full Prescribing Information for Jakafi.

Experience with Jakafi since FDA approval[3]*

7+ YEARS MORE THAN **30,000 PATIENTS TREATED**

* Estimated total patients treated with commercially available Jakafi in the US since 2011.[3]

See Prescribing Information for FDA-approved indications.

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Jakafi® ruxolitinib (tablets)