ELIGIBILITY:

- Polycythemia vera resistant or intolerant to hydroxyurea defined as below:
  - **Resistance**: after 3 months of hydroxyurea at the maximally tolerated dose, patients show one of the followings:
    - need for phlebotomy to maintain HCT below 45%, or
    - platelet > $400 \times 10^9$ /L and WBC > $10 \times 10^9$ /L, or
    - failure to reduce splenomegaly extending greater than 10 cm below the costal margin by > 50%, as measured by palpation
  - **Intolerance**: one of the following after any dose of hydroxyurea:
    - ANC < $1.0 \times 10^9$ /L or platelet < $100 \times 10^9$ /L or hemoglobin < 100 g/L at the lowest hydroxyurea dose required to achieve a response, defined as:
      - HCT < 45% without phlebotomy, and/or all of the followings: platelet < $400 \times 10^9$ /L, WBC < $10 \times 10^9$ /L and non-palpable spleen
    - Grade 3 to 4 non-hematologic toxicities (e.g., leg ulcers, mucocutaneous manifestations, GI symptoms, pneumonitis, or fever at any dose of hydroxyurea)
    - More than 1 week of grade 2 toxicities, permanent discontinuation of hydroxyurea, interruption of hydroxyurea until toxicity resolved, or hospitalization due to hydroxyurea toxicity
  - A BC Cancer “Compassionate Access Program” (CAP) request with appropriate clinical information (bone marrow report, cytogenetic report [if done], recent complete blood count and recent clinic progress note) for each patient must be approved prior to treatment. Initial CAP approval for 24 weeks. To continue treatment, apply to CAP for re-approval. Subsequent re-approvals through CAP will be required every 12 months.

TESTS:

- CBC, platelets, differential
  - Baseline
  - During dosage titration: (physician will check and advise patient on dose adjustment)
    - First 3 months: every 1-2 weeks
    - 3-6 months: every 2-4 weeks
    - After 6 months of therapy: every 1-3 months
- Serum creatinine
  - baseline
  - regularly for patients with renal impairment
- Bilirubin, AST
  - baseline
  - regularly for patients with hepatic impairment
- ECG – baseline and as clinically indicated
- HBsAg, HBcoreAb at baseline (results do not have to be available to proceed with first treatment; results must be checked before proceeding with further treatment)

**SUPPORTIVE MEDICATIONS:**
If HBsAg or HBcoreAb positive, start lamiVUDine 100 mg/day PO for the duration of chemotherapy and for six months afterwards.

**PREMEDICATIONS:**
None

**TREATMENT:**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Platelet* (x 10⁹/L)</th>
<th>Dose**</th>
<th>BC Cancer Administration Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>ruxolitinib</td>
<td>100 or greater</td>
<td>Start at 10 mg BID</td>
<td>PO</td>
</tr>
<tr>
<td></td>
<td>50 to less than 100</td>
<td>Start at 5 mg BID</td>
<td></td>
</tr>
</tbody>
</table>

* Plus ANC greater or equal 1.0 x 10⁹/L
** May increase dose 8 weeks after initiation, and then at intervals of 2 weeks or longer. Platelet should be 125 x 10⁹/L or higher and ANC 0.75 x 10⁹/L or higher. Dose may be increased by a maximum of 5 mg BID up to a dose of 25 mg BID.

Assess response after 24 weeks.

**DOSE MODIFICATIONS:**

1. **Hematological:**

<table>
<thead>
<tr>
<th>Hemoglobin (g/L)</th>
<th>Platelet (x 10⁹/L)</th>
<th>ANC (x 10⁹/L)</th>
<th>Total daily dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 80</td>
<td>or Less than 50</td>
<td>or Less than 0.5</td>
<td>Hold until recovery of blood counts, then restart at 5 mg BID</td>
</tr>
</tbody>
</table>
Dosing recommendations for thrombocytopenia

<table>
<thead>
<tr>
<th>Platelet Count (x 10⁹/L)</th>
<th>Dose at Time of Platelet Decline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25 mg BID</td>
</tr>
<tr>
<td></td>
<td>New dose</td>
</tr>
<tr>
<td>100 to less than 125</td>
<td>20 mg BID</td>
</tr>
<tr>
<td>75 to less than 100</td>
<td>10 mg BID</td>
</tr>
<tr>
<td>50 to less than 75</td>
<td>5 mg BID</td>
</tr>
<tr>
<td>Less than 50</td>
<td>Hold until recovery, then restart at 5 mg BID</td>
</tr>
</tbody>
</table>

2. Renal dysfunction:

<table>
<thead>
<tr>
<th>Renal dysfunction</th>
<th>Platelet (x 10⁹/L)</th>
<th>Dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creatinine clearance less than 50 mL/min</td>
<td>greater than or equal to 100</td>
<td>5 mg BID starting dose</td>
</tr>
<tr>
<td></td>
<td>less than 100</td>
<td>Avoid</td>
</tr>
<tr>
<td>On dialysis</td>
<td>100 or greater</td>
<td>10 mg single dose after hemodialysis</td>
</tr>
<tr>
<td></td>
<td>less than 100</td>
<td>Avoid</td>
</tr>
</tbody>
</table>

PRECAUTIONS:
1. Anemia and thrombocytopenia: patients may require dose adjustment (see above) and transfusion support. Platelet nadir at approx 4 weeks, hemoglobin nadir at approximately 12 weeks.
2. Arrhythmia: A decrease in heart rate and prolongation of PR interval was noted on ECG in ruxolitinib treated patients. The clinical significance of these findings remains unclear.
3. Hepatic dysfunction: consider reducing dose in patients with hepatic impairment (e.g., start at 10 mg BID).
4. Infections: hepatitis B, tuberculosis, JC virus and herpes zoster infections have been reported. Incidence of herpes zoster in ruxolitinib treated polycythemia vera patients was 6.4% over 32 weeks.
5. Progressive multifocal leukoencephalopathy (PML): has been reported.
6. **Non-melanoma skin cancer (NMSC):** includes basal cell, squamous cell, and Merkel cell carcinoma. Most patients had previously treated with long duration of hydroxyurea and prior history of NMSC or pre-malignant skin lesions. Patients should minimize exposure to risk factors for skin cancer while on ruxolitinib.

7. **Lipid abnormalities:** include increases in total cholesterol, LDL, cholesterol, and triglycerides.

Call Dr. Donna Forrest or tumour group delegate at (604) 875-4337 with any problems or questions regarding this treatment program.

**References:**