Besremi (ropeginterferon alfa-2b-njft)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Polycythemia vera ☐ Essential thrombocythemia ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is this medication being used as part of a clinical trial? ☐ Yes ☐ No

Does the patient have presence of Janus kinase 2 mutation (JAK2V617F)?
☐ Yes ☐ No *Must submit lab value documentation*

Will ropeginterferon alfa-2b-njft be used in combination with other interferon type products (e.g., alfa-, beta-, gamma- interferon)? ☐ Yes ☐ No

<u>For diagnosis of polycythemia vera, please answer the following:</u>
Is the patient's hemoglobin greater than 16.5 g/dL (for men) or greater than 16 g/dL (for women)?
☐ Yes ☐ No *Must submit lab value documentation*

Is the patient's hematocrit greater than 49% (for men) or greater than 48% (for women)?
☐ Yes ☐ No *Must submit lab value documentation*

Does the patient have an increased red blood cell mass (>25% above normal)?
☐ Yes ☐ No *Must submit lab value documentation*

Does the patient have bone marrow with tri-lineage proliferation with pleomorphic mature megakaryocytes+?
☐ Yes ☐ No *Must submit documentation*

Does the patient have a subnormal erythropoietin level (as indicated by lab limits)?
☐ Yes ☐ No *Must submit lab value documentation*

Is the patient a transplant recipient on immunosuppressive therapy? ☐ Yes ☐ No

Does the member have a history of an active and serious or untreated autoimmune disease? ☐ Yes ☐ No Please provide documenation.

Will this medication be used in combination with myelosuppressive agents or in the presence of serious or untreated endocrine disorders associated with an autoimmune disease and severe or unstable cardiovascular disease? ☐ Yes ☐ No *If the answer to this question is yes please provide details.*

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Will ropeginterferon alfa-2b-njft be used as a single agent therapy? (Note: excludes use when transitioning from hydroxyurea.) □ **Yes** □ **No**

Does the member have a documented failure, contraindication, or ineffective response to the maximum tolerated doses of hydroxyurea for a minimum 3-month trial as showcased by a HCT > 45%? □ **Yes** □ **No** ***Must provide dates and dosage of hydroxyurea along with documented lab values within that timeframe and after***

For renewal, please answer the following:
Polycythemia Vera:
Has the member maintained hematological stability as evidenced by ALL of the following parameters? ***Must provide chart note and lab value documentation***

- **Hematocrit < 45% and no phlebotomy in the preceding 2 months**
- **Platelets ≤ 400 x 10^9/L**
- **Leukocytes ≤ 10 x 10^9/L?**

Will the member attempt a dosing interval increase to 4 weeks if they have maintained a complete hematological response or hematological stability after 1 year of treatment at stable doses? □ **Yes** □ **No**

***Essential thrombocythemia*:**
Is patient diagnosed with high-risk Essential thrombocythemia(ET)? □ **Yes** □ **No Please provide documenation.**

Has patient had disease-related thrombosis or hemorrhage in the past? □ **Yes** □ **No Please provide documenation.**

Does patient have documented resistance or intolerance to hydroxyurea, as documented with at least one of the following criteria? □ **Yes** □ **No Please provide documenation.**
□ **Platelet count >600 x 10^9/L at ≥2 g/day (or ≥2.5 g/day if subject body weight >80 kg) or maximally tolerated dose if <2 g/day after at least 3 months of HU, OR**
□ **Platelet count >400 x 10^9/L and WBC count <2.5 x 10^9/L at any dose and any duration of HU, OR**
□ **Platelet count >400 x 10^9/L and hemoglobin (HGB) <10 g/dL at any dose and any duration of HU, OR**
□ **presence of HU-related toxicities at any dose and any duration of therapy (e.g., leg ulcers, mucocutaneous manifestations, pneumonitis, or HU-related fever), OR**
□ **Platelet count >450 x 10^9/L at any dose and any duration of HU**

Does patient have a platelet count >450 x 10^9 /L (or >450,000/µL)? □ **Yes** □ **No Please provide documenation.**

Does patient have a HgB ≥11g/dL and 10g/dL for women? □ **Yes** □ **No Please provide documenation.**

Does patient have a documented resistance or intolerance to a 3-month trial of anagrelide(Agrylin)? □ **Yes** □ **No Please provide documenation.**

Does patient have an absolute contraindication to anagrelide? □ **Yes** □ **No Please provide documenation.**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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