Inrebic (fedratinib)
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**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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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:**
☐ Myelofibrosis ☐ Other diagnosis: _____ICD-10_____	

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

Clinical Information:

Does the patient have a diagnosis of myelofibrosis (primary, post-polycythemia vera, or post-essential thrombocythemia)? ☐ **Yes** ☐ **No** ***Please submit documentation***

Does the patient have constitutional symptoms? ☐ **Yes** ☐ **No** ***Please submit documentation***

Does have a hemoglobin level less than 10 g/dL? ☐ **Yes** ☐ **No** ***Please submit documentation***

Does the patient have a WBC count greater than 25 x 10^9/ L ? ☐ **Yes** ☐ **No** ***Please submit documentation***

Does the patient have blood blasts on a peripheral smear equaling 1% or greater?
☐ **Yes** ☐ **No** ***Please submit documentation***

Does the patient have an enlarged spleen at least 5cm below the costal margin?
☐ **Yes** ☐ **No** ***Please submit documentation***

Has the patient undergone a bone marrow biopsy including semiquantitative evaluation of fibrosis, which showed megakaryocytic proliferation and atypia accompanied by either reticulin and/or collagen fibrosis grades 2 or 3?
☐ **Yes** ☐ **No** ***Please submit documentation***

Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0, 1 or 2 (is ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours)?
☐ **Yes** ☐ **No**

Does the patient have an absolute neutrophil count (ANC) equaling at least 1.0 x 10^9/ L?
☐ **Yes** ☐ **No** ***Please submit documentation***

Does the patient have a platelet count of at least 50 x 10^9/ L? ☐ **Yes** ☐ **No** ***Please submit documentation***

Has the patient received prior treatment with a JAK2 inhibitor (such as ruxolitinib/ Jakafi® or fedratinib/ Inrebic®)?
☐ **Yes** ☐ **No** ***Please submit documentation***

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

***Please note:** Not all drugs/diagnoses 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:** _____

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