Jakafi (ruxolitinib)
Prior Authorization Request Form

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

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

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:**
REQUESTER (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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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 ☐ Polycythemia vera ☐ Acute Graft-versus-host-disease (GVHD) ☐ Chronic Graft vs. Host Disease (cGVHD) ☐ Other diagnosis: _____ ICD-10 Code(s):	

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

Is patient going to be using drug in combination with a clinical trial? ☐ Yes ☐ No

Will patient use Jakafi(ruxolitinib) in combination with Ojjaara(momelotinib), Inrebic(fedratinib), or Vonjo(pacritinib)?

<u>For myelofibrosis, answer the following</u>:
Does the patient have a diagnosis <u>of intermediate 2 or high risk myelofibrosis</u> (including primary myelofibrosis, post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis)?□ Yes □ No

Does the patient meet at least 2 of the 5 following risk factors for Intermediate 2 and/or High Risk myelofibrosis?
□ Yes □ No Please check all that apply:
□ Age 66 years or older
□ Constitutional symptoms, as documented in submitted chart notes
□ Hemoglobin less than 10 g/dL, as documented in a submitted lab report
□ WBC count greater than 25 x 10^9/ L, as documented in a submitted lab report
□ Blood blasts on peripheral smear equaling at least 1%, as documented in a submitted lab report;

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

Has 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 include a copy of the bone marrow biopsy report.

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Does patient have a peripheral-blood blast count equaling less than 10% (lab report required)? □ Yes □ No Please submit documentation.

Does the patient have abnormal blood cells, confirmed by a peripheral blood smear report? □ Yes □ No
Please include a copy of the peripheral blood smear report

Does patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0, 1 or 2? □ Yes □ No Please submit documentation.

Has patient received prior treatment with a JAK2 inhibitor (such as ruxolitinib/ Jakafi® or fedratinib/ Inrebic®)
Has the diagnosis of myelofibrosis been verified with a bone marrow biopsy? □ Yes □ No

<u>For polycythemia vera, answer the following:</u>
Does the patient have documentation of polycythemia vera? □ Yes □ No

Has the patient had an inadequate response or intolerance to hydroxyurea? □ Yes □ No

<u>For acute graft-versus-host-disease(GVHD), answer the following</u>:

Has patient had a history of hematologic malignancy? □ Yes □ No *Please provide documentation*.

Has patient undergone ONLY one allogeneic hematopoetic stem cell transplant? □ Yes □ No *Please provide documentation*.

Does patient have GVHD overlap ("acute on chronic") syndrome (as defined by NIH guidelines)? □ Yes □ No *Please provide documentation*.

Does the patient's acute GVHD involve the liver and/or upper GI tract and/or lower GI tract and/or >50% body surface area of the skin? □ Yes □ No *Please provide documentation*.

Has the patient's acute GVHD progressed after 3 or more days of methylprednisolone > 2mg/kg/day(or equivalent)? □ Yes □ No *Please provide documentation*.

Did the patient's acute GVHD show no improvement after 7 days of methylprednisolone > 2mg/kg/day(or equivalent)? □ Yes □ No *Please provide documentation*.

Has the patient's acute GVHD developed in another organ after receiving methylprednisolone <u>≥</u>1 mg/kg/day (or equivalent) for skin GVDH or skin/upper GI GVDH? □ Yes □ No *Please provide documentation*.

Has the patient been unable to tolerate tapering from corticosteroids? □ Yes □ No *Please provide documentation*.

<u>For Chronic Graft vs. Host Disease (cGVHD), answer the following:</u>

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Has the patient undergone an allogeneic stem cell transplantation? □ **Yes** □ **No**

Has the patient had a trial with systemic corticosteroids for the treatment of cGVHD? □ **Yes** □ **No**

Does the patient have a confirmed diagnosis of glucocorticoid-refractory or glucocorticoid-dependent cGVHD defined per 2014 National Institutes of Health (NIH) consensus criteria as a lack of response or disease progression after administration of minimum prednisone 1 mg/kg/day for ≥1 week (or equivalent) OR disease persistence without improvement despite continued treatment with prednisone at >0.5 mg/kg/dayor 1 mg/kg/every other day for ≥4 weeks (or equivalent) OR Increase to prednisone dose to >0.25 mg/kg/day after two unsuccessful attempts to taper the dose (or equivalent) □ **Yes** □ **No**

Renewal for Graft versus Host Disease:
Does the patient have active disease? □ **Yes** □ **No**
Is the patient requiring a taper dose schedule in order to wean off Jakafi(ruxolitinib)? □ **Yes** □ **No**

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/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:** _____

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
Phone: 877-228-7909