

Vonjo (pacritinib)
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:	

Continued next page

Vonjo (pacritinib)
Prior Authorization Request Form
Caterpillar Prescription Drug Benefit
 Phone: 877-228-7909 Fax: 800-424-7640

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

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): _____

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 CODE(S): _____

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

Clinical Information:
 Is the drug going to be used in conjunction with a clinical trial? Yes No
 Will patient use Vonjo(pacritinib) in combination with Ojjaara(momelotinib), Inrebic(fedratinib), or Jakafi(ruxolitinib)? Yes No Please provide documentation.
 Does patient have a diagnosis of intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis, per WHO & IWG-MRT criteria? Yes No Please provide documentation.
 Has patient tried and failed to have benefit with prior treatment with Jakafi (ruxolitinib)? Yes No Please provide documentation.
 Did patient have treatment with greater than or equal to 3 months with Jakafi(ruxolitinib) with inadequate efficacy? Yes No Please provide documentation.
 Was patient's response to Jakafi represented with less than 10% SVR by MRI or less than 30% decrease from baseline in spleen length? Yes No Please provide documentation.



Vonjo (pacritinib)
Prior Authorization Request Form
Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

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

Was treatment with Jakafi greater than or equal to 28 days AND complicated by a development of a red blood cell (RBC) transfusion requirement(at least 2 units/month for 2 months)? Yes No Please provide documentation.

Was treatment with Jakafi greater than or equal to 28 days AND complicated by a National Cancer Institute (NCI) CTCAE grade greater than or equal to 3 adverse events of thrombocytopenia, anemia, hematoma, and/or hemorrhage while being treated with a dosage of greater than 20 mg twice daily? Yes No Please provide documentation.

Does patient have palpable splenomegaly greater than or equal to 5 cm below the lower costal margin (LCM) in the midclavicular line? Yes No Please provide documentation.

Does patient have a TSS of greater than or equal to 10 on the MPN-SAF TSS 2.0? Yes No Please provide documentation.

Does patient have a single symptom score of greater than or equal to 5? Yes No Please provide documentation.

Does patient have 2 symptoms of greater than or equal to 3, including only the symptoms of left upper quadrant pain, bone pain, itching, or night sweats? Yes No Please provide documentation.

Does patient have an Eastern Cooperative Oncology Group(ECOG) performance status of 0 to 2? Yes No Please provide documentation.

Does patient have a peripheral blast count of less than 10%? Yes No Please provide documentation.

Does patient have an absolute neutrophil count greater than 500 microliters? Yes No Please provide documentation.

Is patient NYHA Class II, III, or IV heart failure? Yes No

Does patient have history of spleen removal or allogenic stem cell transplant? Yes No Please provide documentation.

Vonjo (pacritinib)
Prior Authorization Request Form
Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

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

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: _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

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