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:**
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):			

Continued on next page.

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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 ☐ Other diagnosis: _____ICD-10_____	

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

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.

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.

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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.

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

Revision Date: 11/01/2022

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