Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Jakafi® (ruxolitinib)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:
- ☐ Jakafi 5 mg tablet
- ☐ Jakafi 10 mg tablet
- ☐ Jakafi 15 mg tablet
- ☐ Jakafi 20 mg tablet
- ☐ Jakafi 25 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Patient must meet all of the following criteria for initial 12-week authorization:

1. Must have one of the following:
   - Myelofibrosis and at intermediate or high-risk, including primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis, or
   - Polycythemia vera with an inadequate response to hydroxyurea
2. Complete blood count before starting therapy (platelet count more than 100 x 10^9/L) and monitored every 2 to 4 weeks until dosing is stable, then as clinically necessary

For continuation, patient must have met the following requirements:

1. Must have one of the following:
   - Myelofibrosis and at intermediate or high-risk, including primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis, or
   - Polycythemia vera with an inadequate response to hydroxyurea
2. The patient has experienced a 35% reduction in spleen volume (approximately a 50% reduction in spleen size on palpation.

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2015

Last reviewed 07/2018

PriorityHealth

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Myelofibrosis and at intermediate or high-risk because of:
  - ☐ primary myelofibrosis
  - ☐ post-polycythemia vera myelofibrosis
  - ☐ post-essential thrombocythemia myelofibrosis
- ☐ Polycythemia vera, and
  - ☐ patient tried hydroxyurea and had an inadequate response
- ☐ Other – the patient's condition is: _____

Rationale for use: _____

B. Which of the following puts the patient at intermediate or high-risk?

C. What is the patient's platelet count? _____ Date of lab: _____

D. The prescriber will perform a complete blood count every 2 to 4 weeks until dosing is stable. ☐ Yes ☐ No

Request to continue a previously authorized approval
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ myelofibrosis and at intermediate or high-risk because of:
  - ☐ primary myelofibrosis
  - ☐ post-polycythemia vera myelofibrosis
  - ☐ post-essential thrombocythemia myelofibrosis
- ☐ polycythemia vera, and
  - ☐ patient tried hydroxyurea and had an inadequate response
- ☐ Other – the patient's condition is: _____

B. Which of the following puts the patient at intermediate or high-risk?

- ☐ primary myelofibrosis
- ☐ post-polycythemia vera myelofibrosis
- ☐ post-essential thrombocythemia myelofibrosis

C. Did the patient had a 35% reduction in spleen volume after 12 weeks of starting Jakafi (about a 50% reduction in spleen size on palpation)?

- ☐ Yes
- ☐ No – rationale for continued use: _____

Additional information

Note: Jakafi is a limited distribution drug. It must be filled at a network specialty pharmacy.

Patients with platelet counts less than 200 $x10^9$/L at the start of therapy are more likely to develop thrombocytopenia during treatment.

Table 1. Recommended starting dose

Platelet Count	Starting Dose
More than 200$x10^9$/L	20 mg orally twice daily
Between 100$x10^9$/L and 200$x10^9$/L	15 mg orally twice daily

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Last reviewed 07/2018