PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

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 oral tablet

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically accepted indication*
2. For primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis: must be at intermediate or high risk
3. Physician must be familiar with the FDA labeling and dose modification information for Jakafi
4. Must have a Complete Blood Count (CBC) prior to initiating therapy (platelet count > 50 x 10^9/L) with monitoring every 2 to 4 weeks until dose is stabilized, then as clinically necessary
5. Must be age 12 or older

For continuation, patient must have met the following requirements:

1. Must have experienced a 35% reduction in spleen volume (approximately a 50% reduction in spleen size on palpation)

Additional information

Note: When criteria are met, initial approval is for 12 weeks and continuation approval is for 12 months

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2020
Last reviewed 01/2020

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Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication for a drug or biologic used in an anti-cancer chemotherapeutic regimen is a use that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- supported by one of the following references (known as compendia): National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Micromedex DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology, or Lexi-Drugs
- –– *or* –– supported in peer-reviewed medical literature appearing in regular editions of approved publications

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Myelofibrosis (including primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis)

1. Is the patient at intermediate or high-risk?

☐ Yes

☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____

☐ No

☐ Polycythemia vera

1. Did the patient have an inadequate response to or is intolerant of hydroxyurea?

☐ Yes

☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____

☐ No

☐ Graft-versus-host disease (GVHD), acute and steroid-refractory

☐ *Other – the patient's condition is:* _____

Rationale for Other use: _____

B. Did the patient have a CBC with a platelet count > 50 x 10^9/L prior to initiating therapy?

☐ Yes. **Platelet count:** _____ **Date of lab:** _____

☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____

☐ No

C. Will the CBC be monitored every 2 to 4 weeks until dose is stabilized and then as clinically necessary?

☐ Yes

☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____

☐ No

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D. Is the physician familiar with the FDA-labeling and dose modification information for Jakafi?
(Including adjustment for use with a strong CYP3A4 inhibitor [e.g., boceprevir, clarithromycin, conivaptan, grapefruit juice, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole, etc], renal or hepatic impairment, thrombocytopenia, and treatment interruption)

☐ Yes
☐ No. **Are you requesting an exception to the criteria?**
  ☐ Yes. ***Rationale for exception***: _____
  ☐ No

Continuation
Priority Health Precertification Documentation

A. Did the patient have a 35% reduction in spleen volume (about a 50% reduction in spleen size on palpation)?

☐ Yes
☐ No. **Are you requesting an exception to the criteria?**
  ☐ Yes. ***Rationale for exception***: _____
  ☐ No

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Jakafi likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using Jakafi, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: _____

_____

_____

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Last reviewed 01/2020