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 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: _____

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 have one of the following diagnoses or another medically-accepted indication*:
   - Intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis
   - Polycythemia vera with an inadequate response or intolerance to hydroxyurea
2. Must have a complete blood count (CBC) before starting therapy (platelet count > 50 x 10^9/L) with monitoring every 2 to 4 weeks until dosing is stable, then as clinically necessary
3. Physician is familiar with the FDA labeling and dose modification information for Jakafi
4. Must be age 18 or older

For continuation, patient must have met the following requirements:

1. The patient has experienced a 35% reduction in spleen volume (approximately a 50% reduction in spleen size on palpation)

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2019
Last reviewed 01/2019

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 is a use of the drug 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.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Additional information

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

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Myelofibrosis 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 or was intolerant to hydroxyurea
- ☐ Other – the patient's condition is: _____

Rationale for Other use: _____

B. Is the patient's platelet count > 50 x 10^9/L?

- ☐ Yes. **Platelet count:** _____ **Date of lab:** _____
- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

C. The prescriber:

- ☐ Will perform a complete blood count every 2 to 4 weeks until dosing is stable and then as clinically necessary
- ☐ is familiar with the FDA-labeling and dose modifications for Jakafi including adjustment for concomitant 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

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

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Last reviewed 01/2019

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 01/2019