



Besremi (ropeginterferon alfa-2b-njft)

Prior Authorization Request Form

Caterpillar Prescription Drug Benefit

Phone: 877-228-7909 Fax: 800-424-7640



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: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Polycythemia vera <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p>Is this medication being used as part of a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient's hemoglobin greater than 16.5 g/dL (for men) or greater than 16 g/dL (for women)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Must submit lab value documentation</i></p> <p>Is the patient's hematocrit greater than 49% (for men) or greater than 48% (for women)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Must submit lab value documentation</i></p> <p>Does the patient have an increased red blood cell mass (>25% above normal)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Must submit lab value documentation</i></p> <p>Does the patient have presence of Janus kinase 2 mutation (JAK2V617F)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Must submit lab value documentation</i></p> <p>Does the patient have bone marrow with tri-lineage proliferation with pleomorphic mature megakaryocytes+? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Must submit documentation</i></p> <p>Does the patient have a subnormal erythropoietin level (as indicated by lab limits)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Must submit lab value documentation</i></p> <p>Does the patient have a history of severe psychiatric disorders (e.g., depression, suicidal ideation, suicide attempt(s), etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have moderate (Child Pugh B) or severe (Child Pugh C) hepatic impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient a transplant recipient on immunosuppressive therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the member have a history of an active and serious or untreated autoimmune disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will this medication be used in combination with myelosuppressive agents or in the presence of serious or untreated endocrine disorders associated with an autoimmune disease and severe or unstable cardiovascular disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If the answer to this question is yes please provide details.</i></p>		





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Does the member have stage 4 renal impairment (i.e., eGFR is < 30 mL/min)?

Yes No *Must submit lab value documentation*

Will ropeginterferon alfa-2b-njft be used in combination with other interferon type products (e.g., alfa-, beta-, gamma- interferon)? Yes No

Will ropeginterferon alfa-2b-njft be used as a single agent therapy? (Note: excludes use when transitioning from hydroxyurea.) Yes No

Does the member have a documented failure, contraindication, or ineffective response to the maximum tolerated doses of hydroxyurea for a minimum 3-month trial as showcased by a HCT > 45%?

Yes No *Must provide dates and dosage of hydroxyurea along with documented lab values within that timeframe and after*

For renewal, please answer the following:

Has the member maintained hematological stability as evidenced by ALL of the following parameters? *Must provide chart note and lab value documentation*

- Hematocrit < 45% and no phlebotomy in the preceding 2 months
- Platelets $\leq 400 \times 10^9/L$
- Leukocytes $\leq 10 \times 10^9/L$

Will the member attempt a dosing interval increase to 4 weeks if they have maintained a complete hematological response or hematological stability after 1 year of treatment at stable doses?

Yes No

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:** _____

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

