



Jakafi (Ruxolitinib)
Prior Authorization Request Form
 Caterpillar Prescription Drug Benefit



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? 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:**

<input type="checkbox"/> Myelofibrosis <input type="checkbox"/> Polycythemia vera <input type="checkbox"/> Acute Graft-versus-host-disease (GVHD) <input type="checkbox"/> Chronic Graft vs. Host Disease (cGVHD) <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____	
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3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

For myelofibrosis, answer the following:

Does the patient have a diagnosis of intermediate or high risk myelofibrosis (including primary myelofibrosis, post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis)? Yes No

Has the diagnosis of myelofibrosis been verified with a bone marrow biopsy? Yes No
 Please include a copy of the bone marrow biopsy report

Does the patient have abnormal blood cells, confirmed by a peripheral blood smear report? Yes No
 Please include a copy of the peripheral blood smear report

For polycythemia vera, answer the following:

Does the patient have documentation of polycythemia vera? Yes No

Has the patient had an inadequate response or intolerance to hydroxyurea? Yes No

For acute graft-versus-host-disease(GVHD), answer the following:

Has patient had a history of hematologic malignancy? Yes No *Please provide documentation.*

Has patient undergone ONLY one allogeneic hematopoietic stem cell transplant? Yes No *Please provide documentation.*

Does patient have GVHD overlap (“acute on chronic”) syndrome (as defined by NIH guidelines)? Yes No *Please provide documentation.*

Does the patient’s acute GVHD involve the liver and/or upper GI tract and/or lower GI tract and/or >50% body surface area of the skin? Yes No *Please provide documentation.*

Has the patient’s acute GVHD progressed after 3 or more days of methylprednisolone > 2mg/kg/day(or equivalent)? Yes No *Please provide documentation.*





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Did the patient's acute GVHD show no improvement after 7 days of methylprednisolone > 2mg/kg/day (or equivalent)? Yes No *Please provide documentation.*

Has the patient's acute GVHD developed in another organ after receiving methylprednisolone ≥ 1 mg/kg/day (or equivalent) for skin GVDH or skin/upper GI GVDH? Yes No *Please provide documentation.*

Has the patient been unable to tolerate tapering from corticosteroids? Yes No *Please provide documentation.*

In addition to corticosteroids, has patient received MORE THAN one systemic treatment for acute GVHD? Yes No *Please provide documentation.*

For Chronic Graft vs. Host Disease (cGVHD), answer the following:

Has the patient undergone an allogeneic stem cell transplantation? Yes No

Has the patient had a trial with systemic corticosteroids for the treatment of cGVHD? Yes No

Has the patient had a trial with systemic corticosteroids for the treatment of cGVHD? Yes No

Does the patient have a confirmed diagnosis of glucocorticoid-refractory or glucocorticoid-dependent cGVHD defined per 2014 National Institutes of Health (NIH) consensus criteria as a lack of response or disease progression after administration of minimum prednisone 1 mg/kg/day for ≥ 1 week (or equivalent) OR disease persistence without improvement despite continued treatment with prednisone at >0.5 mg/kg/day or 1 mg/kg/every other day for ≥ 4 weeks (or equivalent) OR Increase to prednisone dose to >0.25 mg/kg/day after two unsuccessful attempts to taper the dose (or equivalent) Yes No

Has the patient received have received ≥ 1 systemic therapy with steroid +/- calcineurin inhibitor? Yes No

Does the patient have an absolute neutrophil count (ANC) > 1000/mm³? Yes No *Please provide documentation.*

Does the patient have a platelet count > 25,000/ mm³? 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/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

