OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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# Jakafi® (Ruxolitinib) Prior Authorization Form

***Member Name:*** _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

## Drug Information

***Pharmacy billing (NDC:*** _____***) Start Date (or date of next dose):*** _____

***Dose:*** _____ ***Regimen:*** _____

## Billing Provider Information

***Pharmacy NPI:*** _____ ***Pharmacy Name:*** _____

***Pharmacy Phone:*** _____ ***Pharmacy Fax:*** _____

## Prescriber Information

***Prescriber NPI:*** _____ ***Prescriber Name:*** _____

***Prescriber Phone:*** _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

## Criteria

**For Initial Authorization**

1. **Please indicate the diagnosis and information:**
   - ☐ **Graft-Versus-Host Disease (GVHD)**
     - A. Is diagnosis acute or chronic GVHD? Yes☐ No☐
     - B. Has the member failed at least 1 prior systemic therapy? Yes☐ No☐
   - ☐ **Myelofibrosis (MF)**
     - A. Will ruxolitinib be used for symptomatic lower-risk MF with no response or loss of response to peginterferon alfa-2a or hydroxyurea? Yes☐ No☐
     - B. Will ruxolitinib be used for intermediate to high-risk MF? Yes☐ No☐
   - ☐ **Polycythemia Vera**
     - A. Has member had an inadequate response or loss of response to hydroxyurea or peginterferon alfa-2a therapy? Yes☐ No☐
   - ☐ **If diagnosis is not listed above, please indicate diagnosis:** _____

Additional Information: _____

_____

**For Continued Authorization:**

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on ruxolitinib? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to ruxolitinib therapy? Yes☐ No☐

*If yes, please specify adverse reactions:* _____

_____

**Prescriber Signature:** _____ **Date:** _____

***I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.***

*Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

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|---|---|
| Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.** | CONFIDENTIALITY NOTICE<br><br>*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.* |