OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process**.

Drug Requested: **Jakafi®** (ruxolitinib)

DRUG INFORMATION: Complete information below or authorization will be delayed.

Drug Form/Strength: _____ **Quantity per Day**: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: To receive a **ONE (1) year approval** for the drugs listed below, **ALL** appropriate lines **MUST** be checked to qualify to ensure authorization will NOT be delayed.

- **Does member meet the following criteria?** ❑ Yes ❑ No
  - Does member have a diagnosis of myelofibrosis? ❑ Yes ❑ No
  - Does member have intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis? ❑ Yes ❑ No
  - Does member have polycythemia vera? ❑ Yes ❑ No
    - **If YES, has member had an inadequate response to or is intolerant of hydroxyurea?** ❑ Yes ❑ No

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~12/23/2017:~~ **8/23/2018**