OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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 below. If incomplete, authorization process will be delayed.

Drug Name: _____

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. Authorization process will be delayed if not completed.

- **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