CVS caremark™ {{PANUMCODE}}

Jakafi

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the patient's diagnosis?
   - ❑ Myelofibrosis (e.g., primary myelofibrosis, post-polycythemia vera myelofibrosis, post-essential thrombocythemia myelofibrosis)
   - ❑ Acute myeloid leukemia
   - ❑ Polycythemia Vera
   - ❑ Steroid-refractory acute or chronic graft versus host-disease GVHD
   - ❑ Ph-like B-cell acute lymphoblastic leukemia (ALL)/Lymphoblastic Lymphoma (LL)
   - ❑ Chronic myelomonocytic leukemia (CMML)-2
   - ❑ BCR-ABL negative atypical chronic myeloid leukemia
   - ❑ Essential thrombocythemia
   - ❑ Myeloid/Lymphoid neoplasms with eosinophilia
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this a request for continuation of therapy with the requested drug?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*
4. *If diagnosis is myelofibrosis, acute myeloid leukemia, polycythemia vera, steroid-refractory acute or chronic graft versus host-disease GVHD or essential thrombocythemia,* does the patient have improvement in symptoms and no unacceptable toxicity? ❑ Yes ❑ No *No further questions*
5. *If diagnosis is acute lymphoblastic leukemia (ALL)/lymphoblastic lymphoma (LL), chronic myelomonocytic leukemia (CMML)-2, BCR-ABL negative atypical chronic myeloid leukemia or myeloid/lymphoid neoplasms with eosinophilia,* is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Polycythemia Vera, Essential Thrombocythemia

6. Did the patient have an inadequate response or intolerance to any of the following treatments? *Indicate ALL that apply.*
   - ❑ Yes - Hydroxyurea
   - ❑ Yes - anagrelide
   - ❑ Yes - Interferon therapy (i.e. peginterferon alfa-2a)
   - ❑ No

Section B: Acute Lymphoblastic Leukemia (ALL)/Lymphoblastic Lymphoma (LL)

7. Does the patient have either of the following mutations? ***ACTION REQUIRED: If Yes, attach medial record documentation confirming either a cytokine receptor-like factor 2 (CRLF2) mutation or a mutation associated with activation of the Janus kinase/signal transducers and activators of transcription (JAK/STAT) pathway.***
   - ❑ Yes – Cytokine receptor-like factor 2 (CRLF2) mutation
   - ❑ Yes – A mutation associated with activation of the Janus kinase/signal transducers and activators of transcription (JAK/STAT) pathway
   - ❑ No

Section C: Atypical Chronic Myeloid Leukemia

8. What is the requested regimen?
   - ❑ The requested medication as a single agent
   - ❑ The requested medication in combination with a hypomethylating agent
   - ❑ Other _____

Section D: Chronic Myelomonocytic Leukemia (CMML)-2

9. Will the requested drug be used in combination with a hypomethylating agent? ❑ Yes ❑ No

Section E: Myeloid/Lymphoid Neoplasms with eosinophilia

10. Is the disease in chronic phase or blast phase? ❑ Yes ❑ No

11. Does testing or analysis confirm JAK2 rearrangement? ***ACTION REQUIRED: If Yes, attach medial record documentation of JAK2 rearrangement as confirmed by testing or analysis.*** ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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