CVS caremark™ {{PANUMCODE}}

Vonjo

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 the patient's diagnosis?
   ❑ Myelofibrosis/Acute Myeloid Leukemia
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #5*
4. Has there been an improvement in symptoms without any evidence of unacceptable toxicity while on the current regimen? ❑ Yes ❑ No *No further questions.*
5. Does the patient have symptomatic accelerated phase or blast phase myelofibrosis/acute myeloid leukemia? *If Yes, no further questions.* ❑ Yes ❑ No
6. What's the patient's pretreatment platelet count? ***ACTION REQUIRED: Attach laboratory documentation or chart note(s) with pretreatment platelet count.***
   ❑ Less than 50,000 ❑ 50,000 or greater, *skip to #9* ❑ Unknown
7. Which of the following applies to the patient's disease?
   ❑ Symptomatic low-risk myelofibrosis (MF)
   ❑ Intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF), *no further questions*
   ❑ Other _____
8. Has the patient failed treatment with ruxolitinib (Jakafi), peginterferon alfa-2a, or hydroxyurea?
   ❑ Yes ❑ No *No further questions.*
9. Does the patient have a symptomatic disease (e.g., splenomegaly and other disease-related symptoms)?
   ❑ Yes ❑ No

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10. Which of the following applies to the patient's disease?
    - ❑ High-risk myelofibrosis (MF)
    - ❑ High-risk myelofibrosis (MF)-associated anemia
    - ❑ Other _____

11. Is the patient a candidate for transplant? *If Yes, no further questions* ❑ Yes ❑ No

12. Has the patient failed treatment with one prior JAK inhibitor [e.g., ruxolitinib (Jakafi) or fedratinib (Inrebic)]?
    ❑ 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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