Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Jakafi (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Jakafi (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Jakafi (ruxolitinib)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan? Y N

   [If no, skip to question 6.]

2. Is the medication being used for the treatment of myelofibrosis? Y N

   [If no, skip to question 4.]

3. Did the patient demonstrate benefit from therapy as evidenced by spleen size reduction (at least 35% decrease from baseline in spleen volume) OR symptom improvement (at least 50% reduction in total symptom score from baseline OR the absence of disease Y N

progression?

[No further questions.]

4. Is the medication being used for the treatment of polycythemia vera? Y N

   [If no, then no further questions.]

5. Did the patient demonstrate benefit from therapy as evidenced by hematologic improvement (decreased hematocrit, platelet count or WBC count) OR a reduction in palpable spleen length OR an improvement in symptoms (e.g., pruritus, night sweats, bone pain)? Y N

   [No further questions.]

6. Does the patient have a diagnosis of primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis? Y N

   [If no, skip to question 8.]

7. Does the patient have intermediate or high risk disease as defined by having at least two of the following risk factors? A) Older than 65 years of age, B) Constitutional symptoms (weight loss greater than 10% or unexplained fever or excessive sweats that have been present for more than 1 month), C) Hemoglobin less than 10g/dL, D) WBC count greater than or equal to 25 x 109 /L (25,000 cells per microliter), E) Peripheral blood blasts greater than 1%, F) Platelet count below 100,000/mcL, G) Red cell transfusion, H) Unfavorable karyotype [i.e., complex karyotype or sole or two abnormalities that include +8, −7/7q-, i(17q), inv(3), −5/5q-, 12p- or 11q23 rearrangement] Y N

   [If yes, skip to question 12.]

   [If no, then no further questions.]

8. Does the patient have a diagnosis of polycythemia vera? Y N

   [If no, then no further questions.]

9. Did the patient have a previous treatment failure with hydroxyurea? Y N

   [If no, then no further questions.]

10. Does the patient have an enlarged spleen (splenomegaly) that requires phlebotomy to control symptoms? Y N

    [If no, then no further questions.]

11. Does the patient have a baseline hematocrit of 40-45%? Y N

    [If no, then no further questions.]

12. Did the patient have a baseline platelet count of at least 50x109/L (50,000 platelets per microliter) prior to initiating therapy? Y N

    [If no, then no further questions.]

13. Does the patient show any evidence of infection? Y N

    [If yes, then no further questions.]

14. Is Jakafi prescribed by, or in consultation with, a hematologist/oncologist? Y N

    [If no, then no further questions.]

15. Is the patient 18 years of age or older? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date