Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (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 New Jersey at **1-855-296-0323**.
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 *(circle drug)*

Jakafi (ruxolitinib)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member (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 member demonstrate benefit from therapy as evidenced by any of the following; A) spleen size reduction of greater than or equal to 35 percent OR B) symptom improvement (at least 50 percent reduction in total symptom score from baseline) OR C) the absence of disease progression? Y N

[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 member demonstrate benefit from therapy as evidenced by any of the following: A) hematologic improvement (decreased hematocrit, platelet count or white blood cell (WBC) count) OR B) a reduction in palpable spleen length OR C) an improvement in symptoms (for example, pruritus, night sweats, bone pain)? Y N

   [No further questions.]

6. Does the member 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 member 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 percent from baseline and/or unexplained fever or excessive sweats that have been present for more than 1 month), C) hemoglobin less than 10g/dL, D) white blood cell (WBC) count greater than or equal to 25 x 109/L (25,000 cells per microliter), E) peripheral blood blasts greater than 1 percent, F) platelet count below 100,000/mcL, G) red cell transfusion, H) unfavorable karyotype (for example, 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 11.]

   [If no, then no further questions.]

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

   [If no, then no further questions.]

9. Does the member meet all 3 major criteria or the first 2 major criteria plus the minor criterion below? Y N

   Major Criteria: 1) Hemoglobin greater than 16.5 g/dL in men, greater than 16.0 g/dL in women, OR hematocrit greater than 49 percent in men, greater than 48 percent in women, OR increased red cell mass; 2) Bone marrow biopsy showing hypercellularity for age with trilineage growth (panmyelosis), including prominent erythroid, granulocytic, and megakaryocytic proliferation with pleomorphic, mature megakaryocytes (differences in size); 3) Presence of Janus Kinase 2 JAK2 V617F mutation or Janus Kinase 2 JAK2 exon 12

mutation

Minor Criterion: Subnormal serum erythropoietin level

[If no, then no further questions.]

10. Has the member had an inadequate response or intolerance to hydroxyurea? Y N

[If no, then no further questions.]

11. Did the member 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.]

12. Is the requested drug prescribed by, or in consultation with, a hematologist/oncologist? Y N

[If no, then no further questions.]

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

[If yes, then no further questions.]

14. Has the member been screened for tuberculosis (TB)? Y N

[If no, then no further questions.]

15. Was the screening positive for latent tuberculosis (TB)? Y N

[If no, skip to question 17.]

16. Has the member received treatment for latent tuberculosis (TB) prior to initiating therapy? Y N

[If no, then no further questions.]

17. Is the member 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**