{{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.

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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 (AML)
   ❑ Polycythemia Vera
   ❑ Acute graft-versus-host disease (aGVHD)
   ❑ Chronic graft-versus-host disease (cGVHD)
   ❑ Ph-like B-cell acute lymphoblastic leukemia (ALL)/Lymphoblastic Lymphoma (LL)
   ❑ Chronic myelomonocytic leukemia (CMML)-2
   ❑ BCR-ABL negative atypical chronic myeloid leukemia (aCML)/Myelodysplastic/Myeloproliferative Neoplasms (MDS/MPN) with Neutrophilia
   ❑ Essential thrombocythemia
   ❑ Myeloid/Lymphoid neoplasms with eosinophilia
   ❑ Chimeric antigen receptor (CAR) T-cell induced cytokine release syndrome (CRS)
   ❑ 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 #6*
4. *If diagnosis is myelofibrosis, acute myeloid leukemia (AML), polycythemia vera, acute graft-versus-host-disease (aGVHD), chronic graft-versus-host disease (cGVHD) or essential thrombocythemia,* has there been an improvement in symptoms without any evidence of unacceptable toxicity while on the current regimen?
   ❑ Yes ❑ No *No further questions*
5. *If diagnosis is Ph-like B-cell acute lymphoblastic leukemia (ALL)/lymphoblastic lymphoma (LL), chronic myelomonocytic leukemia (CMML)-2, BCR-ABL negative atypical chronic myeloid leukemia (aCML) 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

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6. Is this a patient's diagnosis either a) Myelofibrosis (e.g., primary myelofibrosis, post-polycythemia vera myelofibrosis, post-essential thrombocythemia myelofibrosis) or b) Acute myeloid leukemia (AML)?
   If Yes, no further questions ❑ Yes ❑ No

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

Section A: Polycythemia Vera, Essential Thrombocythemia

7. Did the patient have an inadequate response or intolerance to at least one of the following treatments?
   Indicate all that apply.
   ❑ Yes - Hydroxyurea ❑ Yes - Peginterferon alfa-2a ❑ Yes - anagrelide ❑ No

Section B: Ph-like B-Cell Acute Lymphoblastic Leukemia (ALL)/Lymphoblastic Lymphoma (LL)

8. Does the patient have either of the following mutations? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results 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/Unknown

Section C: Chronic Myelomonocytic Leukemia (CMML)-2

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

Section D: BCR-ABL Negative Atypical Chronic Myeloid Leukemia (aCML)

10. What is the requested regimen?
    ❑ The requested medication as a single agent
    ❑ The requested medication in combination with a hypomethylating agent
    ❑ Other ____

Section E: Myeloid/Lymphoid Neoplasms with Eosinophilia

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

12. Does testing or analysis confirm JAK2 rearrangement? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results of JAK2 rearrangement as confirmed by testing or analysis.*** ❑ Yes ❑ No ❑ Unknown

Section F: Acute Graft-Versus-Host Disease (aGVHD)

13. Does the patient have steroid-refractory acute graft-versus-host disease? ❑ Yes ❑ No

Section G: Chronic Graft Versus Host-Disease (cGVHD)

14. Has the patient failed at least one prior line of systemic therapy? ❑ Yes ❑ No

Section H: Chimeric Antigen Receptor (CAR) T-cell Induced Cytokine Release Syndrome (CRS)

15. Is the cytokine release syndrome refractory to high-dose corticosteroids and anti-interleukin-6 (anti-IL-6) therapy?
    ❑ 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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