Jakafi (for Maryland only)

Prior Authorization Request

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

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.

Patient's Name: _____ Date: _____
Patient's ID: _____ Patient's Date of Birth: {{MEMBERDOB}}
Physician's Name: _____
Specialty: _____, NPI#: _____
Physician Office Telephone: _____ Physician Office Fax: _____
Request Initiated For: _____

1. What is the patient's diagnosis?
   - ❑ Primary myelofibrosis
   - ❑ Secondary myelofibrosis due to polycythemia vera (PV) (post-PV myelofibrosis)
   - ❑ Secondary myelofibrosis due to essential thrombocythemia (ET) (post-ET myelofibrosis)
   - ❑ Polycythemia Vera
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement?
   ❑ Yes ❑ No *If No, skip to #6 (if applicable)*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ❑ Yes ❑ No ***ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***
5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #6 (if applicable) and complete this form in its entirety.*

Complete the following question if patient's diagnosis is Polycythemia Vera.

6. Has the patient had an inadequate response to or is intolerant of hydroxyurea? ❑ 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)**