OKLAHOMA Health Care Authority

# State of Oklahoma SoonerCare
# Jakafi® (Ruxolitinib) Prior Authorization Form

***Member Name:_____ Date of Birth:_____ Member ID#:_____***

## Drug Information

***Pharmacy billing (NDC:_____) Start Date (or date of next dose):_____***

***Dose:_____ Regimen:_____***

## Billing Provider Information

***Pharmacy NPI:_____ Pharmacy Name:_____***

***Pharmacy Phone:_____ Pharmacy Fax:_____***

## Prescriber Information

***Prescriber NPI:_____ Prescriber Name:_____***

***Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____***

## Criteria

**For Initial Authorization**

1. **Please indicate the diagnosis and information:**
   - ❑ **Graft-Versus-Host Disease (GVHD)**
     - A. Is diagnosis acute or chronic GVHD? Yes____ No____
     - B. Has the member failed at least 1 prior systemic therapy? Yes___ No____
   - ❑ **Myelofibrosis (MF)**
     - A. Will ruxolitinib be used for symptomatic lower-risk MF with no response or loss of response to peginterferon alfa-2a or hydroxyurea? Yes____ No____
     - B. Will ruxolitinib be used for intermediate to high-risk MF? Yes____ No____
   - ❑ **Polycythemia Vera**
     - A. Has member had an inadequate response or loss of response to hydroxyurea or peginterferon alfa-2a therapy? Yes____ No____
   - ❑ **If diagnosis is not listed above, please indicate diagnosis:**_____

Additional Information:_____

_____

**For Continued Authorization:**

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on ruxolitinib? Yes____ No____
3. Has the member experienced adverse drug reactions related to ruxolitinib therapy? Yes___ No___

*If yes, please specify adverse reactions:*_____

_____

**Prescriber Signature:_____ Date:_____**

***I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.***

*Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

| PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO: | CONFIDENTIALITY NOTICE |
|---|---|
| University of Oklahoma College of Pharmacy<br>Pharmacy Management Consultants<br>Product Based Prior Authorization Unit<br><br>Fax: 1-800-224-4014<br>Phone: 1-800-522-0114 Option 4 | *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.* |