PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 6/13/2025
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - Myelofibrosis/Myeloproliferative Neoplasms (If checked, go to 2) ☐
   - Myeloid/Lymphoid Neoplasms with eosinophilia (If checked, go to 4) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
2. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐
3. Has there been an improvement in symptoms without any evidence of unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐
4. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐
5. Is there evidence of disease progression while on the current regimen? **Y** ☐ **N** ☐
6. Is there evidence of unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐
7. What is the diagnosis?
   - Intermediate-2 primary myelofibrosis (If checked, no further questions) ☐
   - High-risk primary myelofibrosis (If checked, no further questions) ☐
   - Secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (If checked, no further questions) ☐
   - Splenomegaly and other disease-related symptoms of MF-associated anemia (e.g., fatigue, weakness, shortness of breath, pale skin) (If checked, no further questions) ☐
   - Accelerated phase myeloproliferative neoplasms (If checked, no further questions) ☐
   - Blast phase myeloproliferative neoplasms (If checked, no further questions) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
8. Is the disease in chronic phase or blast phase? **Y** ☐ **N** ☐

9. 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 (If checked, no further questions) ☐
- No (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date