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:** 7/18/2024
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
_____ **NPI#:** **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**
_

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 patient's diagnosis?
   - Myelofibrosis, myelofibrosis-associated anemia, or myeloproliferative neoplasms (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

3. Is there improvement in symptoms and no unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐

4. What is the clinical setting in which the requested medication will be used?
   - Accelerated phase or blast phase myeloproliferative neoplasm (If checked, go to 5) ☐
   - Low-risk myelofibrosis (If checked, no further questions) ☐
   - Intermediate-risk myelofibrosis (If checked, go to 6) ☐
   - High-risk myelofibrosis (If checked, go to 7) ☐
   - Myelofibrosis-associated anemia (If checked, go to 8) ☐

5. How will the requested medication be used?
   - As a single agent (If checked, no further questions) ☐
   - In combination with azacitidine (If checked, no further questions) ☐
   - In combination with decitabine (If checked, no further questions) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

6. Does the patient have anemia? **Y** ☐ **N** ☐

7. Does the patient have anemia or symptomatic splenomegaly and/or constitutional symptoms (e.g., fatigue, night sweats, fever, weight loss)?
   - Yes, anemia (If checked, no further questions) ☐

Yes, symptomatic splenomegaly and/or constitutional symptoms (e.g., fatigue, night sweats, fever, weight loss) (If checked, no further questions) ☐

No (If checked, no further questions) ☐

8. Does the patient have symptomatic splenomegaly and/or constitutional symptoms (e.g., fatigue, night sweats, fever, weight loss)? **Y** ☐ **N** ☐

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