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:** 10/11/2024
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 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. Has there been an improvement in symptoms without any evidence of 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, go to 6) ☐
   - Intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (If checked, go to 6) ☐
   - High-risk myelofibrosis (If checked, go to 8) ☐
   - Myelofibrosis-associated anemia (If checked, go to 9) ☐

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. What is the patient's pretreatment platelet count? ACTION REQUIRED: Attach test results or chart note(s) with pretreatment platelet count.
   - 50,000 or less (If checked, go to 7) ☐
   - Greater than 50,000 (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

7. Which of the following applies to the patient's disease?

Symptomatic low-risk myelofibrosis (MF) (If checked, no further questions) ☐

Intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF) (If checked, no further questions) ☐

Other, please specify. (If checked, no further questions) ☐

_____

8. Does the patient have a symptomatic disease (e.g., splenomegaly and other disease-related symptoms)? **Y** ☐ **N** ☐

9. 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

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