BlueCross BlueShield Federal Employee Program

JAKAFI
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Jakafi (ruxolitinib)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Jakafi continuously for the last **4 months**, excluding samples? ***Please select answer below:***
   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 2**
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑Brand ❑Generic

3. What is the patient's diagnosis?
   ❑Graft-Versus-Host Disease (GVHD)
   a. Does the patient have chronic graft-versus-host disease? ❑Yes* ❑No
   If YES, has the patient received at least one or two lines of systemic therapy? ❑Yes ❑No
   b. Does the patient have acute graft-versus-host disease? ❑Yes* ❑No
   If YES, please answer the following questions:
   i. Has the patient had allogeneic hematopoietic stem cell transplantation (allo-HCT)? ❑Yes ❑No
   ii. Has the patient had inadequate treatment response to corticosteroid therapy? ❑Yes ❑No*
   If NO, is the patient intolerant to corticosteroids? ❑Yes ❑No
   c. Does the prescriber agree to administer Jakafi within the FDA labeled dose of 20mg per day? ❑Yes ❑No

   ❑Myelofibrosis
   a. What is the type or stage of the myelofibrosis? ***Please select the myelofibrosis below:***
   ❑Intermediate-risk or high-risk myelofibrosis ❑Post-essential thrombocythemia myelofibrosis
   ❑Post-polycythemia vera myelofibrosis ❑Primary myelofibrosis
   ❑Other ***(please specify)***: _____
   b. Does the prescriber agree to administer Jakafi within the FDA labeled dose of 50 mg per day? ❑Yes ❑No

   ❑Polycythemia vera
   a. Has the patient had an inadequate treatment response or is the patient intolerant to hydroxyurea (Hydrea)? ❑Yes ❑No
   b. Does the prescriber agree to administer Jakafi within the FDA labeled dose of 50 mg per day? ❑Yes ❑No

   ❑Other diagnosis ***(please specify):*** _____

4. Will the patient's lipid levels be assessed 8 to 12 weeks from start of therapy and treated as needed? ❑Yes ❑No

5. Does the patient have any serious infections? ❑Yes ❑No

6. Does the prescriber agree to monitor the patient's CBC and platelet counts? ❑Yes ❑No

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Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Jakafi (ruxolitinib)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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1. Has the patient been on Jakafi continuously for the last **4 months**, excluding samples? ***Please select answer below:***
   - ❑ **NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   - ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑ Brand ❑ Generic

3. What is the patient's diagnosis?
   - ❑ Graft-Versus-Host Disease (GVHD)
     - a. Does the patient have chronic-versus-host disease? ❑Yes ❑No*
       ***If NO,** does the patient have graft-versus-host disease in allogenic hematopoietic stem cell transplantation (allo-HCT)? ❑Yes ❑No
     - b. Has the patient had symptomatic improvement? ❑Yes ❑No
     - c. Does the prescriber agree to administer Jakafi within the FDA labeled dose of 20mg per day? ❑Yes ❑No
   - ❑ Myelofibrosis
     - a. What is the type or stage of the myelofibrosis? ***Please select the myelofibrosis below:***
       ❑Intermediate-risk or high-risk myelofibrosis ❑Post-essential thrombocythemia myelofibrosis
       ❑Post-polycythemia vera myelofibrosis ❑Primary myelofibrosis
       ❑Other ***(please specify)***: _____
     - b. Has the patient had symptomatic improvement? ❑Yes ❑No
     - c. Does the patient have a spleen? ❑Yes* ❑No
       ***If YES**, has the patient had a reduction in palpable spleen length or volume? ❑Yes ❑No
     - d. Does the prescriber agree to administer Jakafi within the FDA labeled dose of 50 mg per day? ❑Yes ❑No
   - ❑ Polycythemia Vera
     - a. Has the patient had symptomatic improvement? ❑Yes ❑No
     - b. Does the patient have a spleen? ❑Yes* ❑No
       ***If YES**, has the patient had a reduction in palpable spleen length or volume? ❑Yes ❑No
     - c. Does the prescriber agree to administer Jakafi within the FDA labeled dose of 50 mg per day? ❑Yes ❑No
   - ❑ Other diagnosis ***(please specify):*** _____

4. Does the prescriber agree to monitor the patient's CBC and platelet counts? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Jakafi – FEP MD Fax Form Revised 10/22/2021