Prescriber Criteria Form Jakafi 2024 PA Fax 723-A v1 010124.docx Jakafi (ruxolitinib) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Jakafi (ruxolitinib).

Drug Name: Jakafi (ruxolitinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of myelofibrosis (e.g., lower-risk, intermediate-risk, high-risk, primary, post-polycythemia vera, post-essential thrombocythemia, accelerated phase myelofibrosis, or blast phase myelofibrosis/acute myeloid leukemia)? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of polycythemia vera (PV)? [If no, then skip to question 4.]	Yes	No
3	Has the patient had an inadequate response or intolerance to any of the following: A) hydroxyurea, B) interferon therapy? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of steroid-refractory acute graft-versus-host disease or chronic graft-versus-host disease? [If yes, then no further questions.]	Yes	No
5	Does the patient have a diagnosis of acute lymphoblastic leukemia (ALL)? [If no, then skip to question 7.]	Yes	No
6	Does the patient have a cytokine receptor-like factor 2 (CRLF2) mutation or a mutation associated with activation of the Janus kinase/signal transducers and activators of transcription (JAK/STAT) pathway? [No further questions.]	Yes	No

7	Does the patient have a diagnosis of chronic myelomonocytic leukemia (CMML)-2? [If no, then skip to question 9.]	Yes	No
8	Will the requested drug be used in combination with a hypomethylating agent? [No further questions.]	Yes	No
9	Does the patient have a diagnosis of myelodysplastic syndrome/myeloproliferative neoplasm (MDS/MPN) with neutrophilia? [If no, then skip to question 12.]	Yes	No
10	Will the requested drug be used as a single agent? [If yes, then no further questions.]	Yes	No
11	Will the requested drug be used in combination with a hypomethylating agent? [No further questions.]	Yes	No
12	Does the patient have a diagnosis of essential thrombocythemia? [If no, then skip to question 14.]	Yes	No
13	Has the patient had an inadequate response or loss of response to any of the following: A) hydroxyurea, B) interferon therapy, C) anagrelide? [No further questions.]	Yes	No
14	Does the patient have a diagnosis of myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and janus kinase 2 (JAK2) rearrangement? [If no, then no further questions.]	Yes	No
15	Is the disease in chronic or blast phase?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____