Prescriber Criteria Form

Jakafi 2025 PA Fax 723-A v2 010125.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)? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of accelerated or blast phase myeloproliferative neoplasms? [If yes, then no further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of polycythemia vera (PV)? [If no, then skip to question 6.]	Yes ◯	No ◯
4	Has the patient had an inadequate response or intolerance to both of the following: A) hydroxyurea, B) Besremi (ropeginterferon alfa-2b-njft)? [If yes, then no further questions.]	Yes ◯	No ◯
5	Does the patient have high risk disease? [No further questions.]	Yes ◯	No ◯
6	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 ◯

7	Does the patient have a diagnosis of acute lymphoblastic leukemia (ALL)? [If no, then skip to question 9.]	Yes ◯	No ◯
8	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 ◯
9	Does the patient have a diagnosis of chronic myelomonocytic leukemia (CMML)-2? [If no, then skip to question 11.]	Yes ◯	No ◯
10	Will the requested drug be used in combination with a hypomethylating agent? [No further questions.]	Yes ◯	No ◯
11	Does the patient have a diagnosis of myelodysplastic syndrome/myeloproliferative neoplasm (MDS/MPN) with neutrophilia? [If no, then skip to question 14.]	Yes ◯	No ◯
12	Will the requested drug be used as a single agent? [If yes, then no further questions.]	Yes ◯	No ◯
13	Will the requested drug be used in combination with a hypomethylating agent? [No further questions.]	Yes ◯	No ◯
14	Does the patient have a diagnosis of essential thrombocythemia? [If no, then skip to question 16.]	Yes ◯	No ◯
15	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 ◯
16	Does the patient have a diagnosis of myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and janus kinase 2 (JAK2) rearrangement? [If no, then skip to question 18.]	Yes ◯	No ◯
17	Is the disease in chronic or blast phase? [No further questions.]	Yes ◯	No ◯
18	Does the patient have a diagnosis of T-cell prolymphocytic leukemia?	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:**_____