Prescriber Criteria Form Ojjaara 2025 PA Fax 6190-A v3 010125.docx Ojjaara (momelotinib) 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 Ojjaara (momelotinib).

Drug Name: Ojjaara (momelotinib)

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 intermediate or high-risk myelofibrosis (MF) including primary MF or secondary MF (i.e., post-polycythemia vera or post-essential thrombocythemia)? [If no, then skip to question 3.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of anemia defined as hemoglobin less than 10 grams per deciliter (g/dL) or having transfusion-dependent anemia? [If yes, then skip to question 4.] [If no, then no further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of accelerated or blast phase myeloproliferative neoplasms? [No further questions.]	Yes ◯	No ◯
4	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to Jakafi (ruxolitinib)? [If yes, then no further questions.]	Yes ◯	No ◯
5	Does the patient have a hemoglobin less than 8 grams per deciliter (g/dL)?	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:_____