Prescriber Criteria Form Vonjo 2025 PA Fax 5264-A v1 010125.docx Vonjo (pacritinib) 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 Vonjo (pacritinib).

Drug Name: Vonjo (pacritinib)

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 primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF)? [If no, then skip to question 3.]	Yes ◯	No ◯
2	Does the patient have a platelet count below 50,000 per microliter (mcL)? [No further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of accelerated or blast phase myeloproliferative neoplasms?	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:**_____