Prior Authorization Form

***Note:*** Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

| Patient Information | | Prescriber Information | |
|---|---|---|---|
| Patient Name: | | Prescriber Name: | |
| Health Plan Name: | | Prescriber Address: | |
| Patient Insurance Id: | | | |
| Patient Date of Birth: | | Prescriber Phone: | ( ) |
| Patient Phone: | | Prescriber Fax: | ( ) |
| | | Prescriber Specialty: | |
| | | Prescriber DEA: | |
| | | Prescriber NPI: | |

| Medication & Medical Information | |
|---|---|
| Requested Drug(s) & Strength(s): | [ ] Jakafi 10 mg tablet [ ] Jakafi 15 mg tablet [ ] Jakafi 20 mg tablet [ ] Jakafi 25 mg tablet [ ] Jakafi 5 mg tablet |
| Requested Daily Quantity Limit – Amount: | |
| Requested Daily Quantity Limit – Days: | |
| Expected Length of Therapy: | |
| Directions: | |
| Diagnosis and Diagnosis Codes (ICD-10 Standard Codes): | |
| List drugs used previously to treat the same condition: | |
| Additional clinical information or history. Please include any relevant test results and/or medical record notes: | |

## Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Primary Myelofibrosis

[ ] Post-polycythemia vera myelofibrosis

[ ] Post-essential thrombocythemia myelofibrosis

[ ] Polycythemia vera

[ ] Acute graft versus host disease (aGVHD)

[ ] Chronic graft versus host disease (cGVHD)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q4: What is the member's diagnosis? (Check only one that apply)

[ ] Primary Myelofibrosis

[ ] Post-polycythemia vera myelofibrosis

[ ] Post-essential thrombocythemia myelofibrosis

[ ] Polycythemia vera

[ ] Acute graft versus host disease (aGVHD)

[ ] Chronic graft versus host disease (cGVHD)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q5: Has the member had an inadequate response, intolerance or experienced contraindication(s) to hydroxyurea? (Check only one that apply)

[ ] Yes (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q6: Is the member's disease refractory to steroid therapy? (Check only one that apply)

[ ] Yes (please provide documents suporting it) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q7: Has the member had an inadequate response to at least one or more lines of systemic therapy (e.g., corticosteroids, mycophenolate, etc.)? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q8: Is the requested medication being prescribed by or in consultation with a hematologist/oncologist? (Check only one that apply)

[ ] Yes (please specify the prescriber's specialty) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q9: Is the requested medication being prescribed by or in consultation with a hematologist, oncologist, or a physician experienced in the management of transplant patients? (Check only one that apply)

[ ] Yes (please specify the prescriber's specialty) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

| | |
|---|---|
| ***Attestation:*** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form. | |
| Signature of Prescriber or Authorized Representative: | Date: |
| Print Authorized Representative Name: | |