UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Jakafi ® (ruxolitinib)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval (ALL of the following criteria must be met and documented in submitted chart notes):

- ☐ Medication is prescribed by or in consultation with a physician specializing in the treatment of patients with one of the following diagnoses (select appropriate diagnosis):
  - ☐ Intermediate or high-risk Myelofibrosis:
    - ☐ Primary Myelofibrosis (PMF)
    - ☐ Post-Polycythemia Vera Myelofibrosis
    - ☐ Post-Essential Thrombocythemia Myelofibrosis
  - ☐ Polycythemia Vera with the following:
    - ☐ History of failure, inadequate response, contraindication or intolerance to **one** of the following:
      - ☐ Hydroxyurea **OR**
      - ☐ Interferon therapy
  - ☐ Steroid-Refractory Acute Graft-Versus-Host Disease (GVHD)
    - ☐ The patient is 12 years of age and older
  - ☐ Chronic Graft-Versus-Host Disease
    - ☐ The patient is 12 years of age and older
    - ☐ Trial and failure of at least two systemic therapies (list below)
      - ☐ Medication and dose:_____Details:_____
      - ☐ Medication and dose:_____Details:_____

Re-authorization Criteria:
Updated letter of medical necessity or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to six (6) months
Re-authorization: Up to twelve (12) months

Notes:

- Use appropriate HCPCS code for billing
  Coverage and Reimbursement code look up: https://health.utah.gov/stplan/lookup/CoverageLookup.php HCPCS
  NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date