mercy care

Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecare-forproviders/pharmacy

Janus Associated Kinase Inhibitors
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information				
☐ Inrebic	☐ Jakafi	☐ Other, please specify:		
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No		ICD-10 Code:	Diagnosis:	
What medication(s) have been tried and failed for diagnosis?				
Are there any contraindications to formulary medications? If yes, please specify:		☐ Yes ☐ No	☐ Initial Request	☐ Continuation of Therapy
Directions for Use:		Strength:	Dosage Form:	
		Quantity: Day Supply:	Duration of Therapy/Use:	

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information						
Has member been screened for TB?	☐ Yes	☐ No	Was screening positive for latent TB?	☐ Yes	☐ No	
			Was treatment for latent TB received prior to initiating therapy?	☐ Yes	☐ No	☐ N/A
Is there evidence showing that member has a serious current ACTIVE infection?				☐ Yes	☐ No	

☐ **Myelofibrosis**		
Is baseline PLT count at least 50 X 109/L?	☐ Yes	☐ No
Does member have TWO or more of the following risk factors?	☐ Age >65 years	☐ Red Cell Transfusion
	☐ Constitutional symptoms (weight loss > 10% from baseline AND/OR unexplained fever OR excessive sweats persisting > 1 month)	
	☐ Hemoglobin <10g/dL	☐ WBC count ≥25 x 109/L
	☐ Peripheral Blood blasts >1%	☐ Platelet count <100 X 109/L
	☐ Unfavorable karyotype [complex karyotype OR sole OR two abnormalities that include trisomy 8, 7/7q-, i(17q), inv (3), 5/5q-, 12p- OR 11q23 rearrangement]	

☐ **Additionally, for Inrebic**					
Is documentation showing signs of severe hepatic impairment (baseline bilirubin >3-times ULN)?	☐ Yes	☐ No	Is documentation showing thiamine levels were taken at baseline AND then periodically during therapy to avoid Wernicke's encephalopathy?	☐ Yes	☐ No
☐ **Renewal Request ONLY**					
Was there spleen size reduction ≥ 35%?	☐ Yes	☐ No	Was there symptom improvement (≥50% reduction in total symptom score from baseline)?	☐ Yes	☐ No
Is there absence of disease progression?				☐ Yes	☐ No

☐ **Additionally, for Inrebic Renewal**								
Is documentation showing LFTs AND thiamine levels are being monitored periodically during therapy?							☐ Yes	☐ No
☐ **Polycythemia Vera**								
Is HgB >16.5 g/dL in MEN OR >16.0 g/dL in WOMEN?			☐ Yes	☐ No	Is HCT >49% in MEN OR >48% in WOMEN?		☐ Yes	☐ No
Is there increased red cell mass?	☐ Yes	☐ No	Does a bone marrow biopsy show hypercellularity for age with trilineage growth (panmyelosis), including prominent erythroid, granulocytic AND megakaryocytic proliferation with pleomorphic, mature megakaryocytes (differences in size)?				☐ Yes	☐ No
Is there presence of JAK2 V617F mutation OR JAK2 exon 12 mutation?			☐ Yes	☐ No	Is there subnormal serum erythropoietin level?		☐ Yes	☐ No
☐ **Renewal Request ONLY**								
Was there hematologic improvement (decreased HCT, PLT count or WBC count)?			☐ Yes	☐ No	Was there a reduction in palpable spleen length?		☐ Yes	☐ No
Has there been improvement in symptoms (for example, pruritus, night sweats, bone pain)?							☐ Yes	☐ No
☐ **Acute Graft-Versus-Host Disease**								
Was there inadequate response to steroids after allogenic hematopoietic stem cell transplant?			☐ Yes	☐ No	Is there diagnosis of grade 2-4 disease, based on Mount Sinai Acute GVHD International Consortium criteria?		☐ Yes	☐ No
☐ **Renewal Request ONLY**								
Was there response to treatment?			☐ Yes	☐ No	Are symptoms recurring during OR after taper AND retreatment is needed?		☐ Yes	☐ No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records								

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.