



Fax completed prior authorization request form to 855-247-3677 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/rbha-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:		Height:			
		<input type="checkbox"/> Male	<input type="checkbox"/> Female				
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							
<input type="checkbox"/> Inrebic	<input type="checkbox"/> Jakafi	<input type="checkbox"/> 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:			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Continuation of Therapy	
Directions for Use:		Strength:		Dosage Form:			
		Quantity:	Day Supply:	Duration of Therapy/Use:			
Turn-Around Time for Review							
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was screening positive for latent TB?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
			Was treatment for latent TB received prior to initiating therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
Is there evidence showing that member has a serious current ACTIVE infection?			<input type="checkbox"/> Yes	<input type="checkbox"/> No			
<input type="checkbox"/> Myelofibrosis							
Is baseline PLT count at least 50 X 109/L?			<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Does member have TWO or more of the following risk factors?		<input type="checkbox"/> Age >65 years		<input type="checkbox"/> Red Cell Transfusion			
		<input type="checkbox"/> Constitutional symptoms (weight loss > 10% from baseline AND/OR unexplained fever OR excessive sweats persisting > 1 month)					
		<input type="checkbox"/> Hemoglobin <10g/dL		<input type="checkbox"/> WBC count ≥25 x 109/L			
		<input type="checkbox"/> Peripheral Blood blasts >1%		<input type="checkbox"/> Platelet count <100 X 109/L			
		<input type="checkbox"/> 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]					
<input type="checkbox"/> Additionally, for Inrebic							
Is documentation showing signs of severe hepatic impairment (baseline bilirubin >3-times ULN)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is documentation showing thiamine levels were taken at baseline AND then periodically during therapy to avoid Wernicke's encephalopathy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal Request ONLY							
Was there spleen size reduction ≥ 35%?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there symptom improvement (≥50% reduction in total symptom score from baseline)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is there absence of disease progression?			<input type="checkbox"/> Yes	<input type="checkbox"/> No			

<input type="checkbox"/> Additionally, for Inrebic Renewal					
Is documentation showing LFTs AND thiamine levels are being monitored periodically during therapy?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Polycythemia Vera					
Is HgB >16.5 g/dL in MEN OR >16.0 g/dL in WOMEN?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is HCT >49% in MEN OR >48% in WOMEN?	
Is there increased red cell mass?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there presence of JAK2 V617F mutation OR JAK2 exon 12 mutation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there subnormal serum erythropoietin level?	
<input type="checkbox"/> Renewal Request ONLY					
Was there hematologic improvement (decreased HCT, PLT count or WBC count)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there a reduction in palpable spleen length?	
Has there been improvement in symptoms (for example, pruritus, night sweats, bone pain)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Acute Graft-Versus-Host Disease					
Was there inadequate response to steroids after allogenic hematopoietic stem cell transplant?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there diagnosis of grade 2-4 disease, based on Mount Sinai Acute GVHD International Consortium criteria?	
<input type="checkbox"/> Renewal Request ONLY					
Was there response to treatment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are symptoms recurring during OR after taper AND retreatment is needed?	
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 800-564-5465 to check the status of a request.