



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Jakafi® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Myelofibrosis					
<input type="checkbox"/> Polycythemia vera					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Prescriber's Specialty:					
Is Jakafi prescribed by or in consultation with a hematologist/oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For myelofibrosis, answer the following:					
Select if the patient has one of the following diagnoses:					
<input type="checkbox"/> Primary myelofibrosis					
<input type="checkbox"/> Post-essential thrombocythemia myelofibrosis					
<input type="checkbox"/> Post-polycythemia vera myelofibrosis					
For polycythemia vera, answer the following:					
Has the patient had trial and failure, contraindication, or intolerance to hydroxyurea? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Reauthorization:					
If this is a reauthorization request, answer the following question:					
Is there documentation the patient has had a positive clinical response to Jakafi therapy (e.g., spleen volume reduction, symptom improvement, hematocrit control)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Quantity Limit Requests:					
What is the quantity requested per DAY? _____					
What is the reason for exceeding the plan limitations?					
<input type="checkbox"/> Titration or loading dose purposes					
<input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)					
<input type="checkbox"/> Requested strength/dose is not commercially available					
<input type="checkbox"/> Other: _____					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Jakafi_Comm_2018Feb-W



Jakafi[®] Prior Authorization Request Form (Page 2 of 2)
DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.