EXPRESS SCRIPTS®

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Prior Authorization Request

JAKAVI (ruxolitinib)

Instructions

Please complete Part A and have your physician complete Part B. Completion and submission is not a guarantee of approval. Any fees related to the completion of this form are the responsibility of the plan member. Drugs in the Prior Authorization Program may be eligible for reimbursement if the patient does not qualify for coverage under a primary plan or a government program. Drugs used for indications not approved by Health Canada may be denied. For Quebec plan members, RAMQ exception drug criteria may apply. The decision for approval versus denial is based on pre-defined clinical criteria, primarily based on Health Canada approved indication(s) and on supporting evidence-based clinical protocols. The plan member will be notified whether their request has been approved or denied. Please note that you have the right to appeal the decision made by Express Scripts Canada.

Part A – Patient

Patient information

First Name:	Last Name:	
Insurance Carrier Name/Number:		
Group Number:	Client ID:	
Date of Birth (YYYY/MM/DD):	Relationship: ☐ Employee ☐ Spouse ☐ Dependent	
Language: ☐ English ☐ French	Gender: ☐ Male ☐ Female	
Address:		
City:	Province:	Postal Code:
Email address:		
Telephone (home):	Telephone (cell):	Telephone (work):

Coordination of benefits

Patient Assistance Program	Is the patient enrolled in any patient assistance program? ☐ Yes ☐ No Contact Name: _____ Telephone: _____
Provincial Coverage	Has the patient applied for reimbursement under a provincial plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****
Primary Coverage	Has the patient applied for reimbursement under a primary plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****

Authorization

On behalf of myself and my eligible dependents, I authorize my group benefit provider, and its agents, to exchange the personal information contained on this form. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as my dependents and I are covered by, or are claiming benefits under the present group contract, or any modification, renewal, or reinstatement thereof.

_____ _____

Plan Member Signature Date

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Part B – Prescriber

Please see instructions on page 1 and complete all sections below. Incomplete forms may result in automatic denial. Please do **not** provide genetic test information or results.

SECTION 1 – DRUG REQUESTED

JAKAVI (ruxolitinib)	☐ New request	☐ Renewal request*	
Dose	Administration (ex: oral, IV, etc)	Frequency	Duration

Site of drug administration:

☐ Home ☐ Physician's office/Infusion clinic ☐ Hospital (outpatient) ☐ Hospital (inpatient)

* Please submit proof of prior coverage if available

SECTION 2 – ELIGIBILITY CRITERIA

1. **Please indicate if the patient satisfies the below criteria:**

Primary Myelofibrosis

INITIAL – *6 month approval*

☐ For the treatment of splenomegaly and/or its associated symptoms in an adult with primary myelofibrosis, post polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis

RENEWAL – *12 month approval*

☐ The patient has demonstrated a reduction in spleen size and/or symptom improvement since initiation of JAKAVI

Polycythemia Vera

☐ For the treatment of polycythemia vera (PV) to control hematocrit in an adult, AND

☐ The patient is resistant to or intolerant to hydroxyurea *(Please list prior therapies in the chart below)*

Acute Graft Versus Host Disease

☐ For the treatment of acute graft versus host disease (aGVHD), AND

☐ The patient is 12 years of age or older, AND

☐ The patient is considered steroid dependent or refractory

Chronic Graft Versus Host Disease

☐ For the treatment of chronic graft versus host disease (cGVHD), AND

☐ The patient is 12 years of age or older, AND

☐ The patient is considered steroid dependent or refractory, AND

☐ The patient has had an inadequate response or has a documented intolerance to corticosteroids or another systemic therapy for cGVHD (*Please list prior therapies in the chart below)*

OR

☐ None of the above criteria applies.

Relevant additional information:

2. Please list previously tried therapies

Drug	Dosage and administration	Duration of therapy		Reason for cessation	
		From	To	Inadequate response	Allergy/ Intolerance
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

SECTION 3 – PRESCRIBER INFORMATION

Physician's Name:	
Address:	
Tel:	Fax:
License No.:	Specialty:
Physician Signature:	Date:

Please fax or mail the completed form to Express Scripts Canada®

Fax:
Express Scripts Canada Clinical Services
1 (855) 712-6329

Mail:
Express Scripts Canada Clinical Services
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5