NEW HAMPSHIRE HEALTHY FAMILIES

Phone: (855) 535-1815
Fax: (855) 815-9894

Send To: ❍ AcariaHealth
❍ Specialty Pharmacy Provider:_____
Date: _____ Date Medication Required:_____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Prior Authorization Form
Jakafi

Patient Name: _____	Physician Name: _____
Address: _____	State Lic #_____ DEA # _____
City: _____State: _____Zip:_____	NPI # _____ Specialty: _____
Home Phone: (_____) _____ - _____	Practice Name/Hospital: _____
Work Phone: (_____) _____ - _____	Address: _____
Cell Phone: (_____) _____ - _____	City: _____ State: _____ Zip: _____
Patient Soc. Sec #: _____ Allergies:_____	Physician's Ph: (_____) _____ - _____
Date of Birth: ___/___/___ Sex: ❍ Male ❍Female Weight _____ ❍lbs ❍kg	Physician's Fax: (_____) _____ - _____
Height: _____ BSA: _____ m² ❍See attached demographic sheet	Nurse/Key Office Contact: _____

INSURANCE INFORMATION (Complete or Attach Copies of cards)

Primary Insurance:_____	Secondary Insurance:_____	Rx Card (PBM):_____	Cardholder First Name: _____
City:_____State:_____	City:_____State:_____	PBM BIN: _____	Last Name: _____
Plan #: _____	Plan #: _____	City:_____State:_____	Employer: _____
Group #: _____	Group #: _____	Group #: _____	ID #: _____
Phone: (_____) _____-_____	Phone: (_____) _____-_____	Phone: (_____) _____-_____	Group #: _____

DIAGNOSIS *(Required)*

❍ Primary Myelofibrosis ❍ Secondary Myelofibrosis due to polycythemia vera (PV) ❍ Essential Thrombocythemia (ET)
❍ Other: _____
What is the ICD9 / ICD10 code? _____

PATIENT EVALUATION

1. Is the patient currently receiving Jakafi? ❍ Yes ❍ No *If Yes, skip to #3*

2. What is the patient's risk category? ❍ Low ❍ Intermediate ❍ High

Answer the following questions if patient is currently receiving Jakafi

3. How long has the patient been receiving Jakafi? _____ months

4. Has the patient's spleen size reduced or symptoms improved since initiation of Jakafi therapy? ❍ Yes ❍ No

*****Please attach most recent clinical notes or supportive documentation*****

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
❍ Jakafi				

Physician's Signature: _____ **Date**____/_____/_____