



Phone: (855) 535-1815  
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Send To:  AcariaHealth  
 Specialty Pharmacy Provider: \_\_\_\_\_  
 Date: \_\_\_\_\_ Date Medication Required: \_\_\_\_\_  
 Ship to:  Physician  Patient's Home  Other \_\_\_\_\_

## Prior Authorization Form Jakafi

Patient Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Patient Soc. Sec #: _____ Allergies: _____ Date of Birth: ___/___/___ Sex: <input type="radio"/> Male <input type="radio"/> Female Weight ___ lbs <input type="radio"/> kg Height: _____ BSA: _____ m <sup>2</sup> <input type="radio"/> See attached demographic sheet	Physician Name: _____ State Lic # _____ DEA # _____ NPI # _____ Specialty: _____ Practice Name/Hospital: _____ Address: _____ City: _____ State: _____ Zip: _____ Physician's Ph: (____) _____ - _____ Physician's Fax: (____) _____ - _____ Nurse/Key Office Contact: _____
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### INSURANCE INFORMATION (Complete or Attach Copies of cards)

Primary Insurance: _____ City: _____ State: _____ Plan #: _____ Group #: _____ Phone: (____) _____ - _____	Secondary Insurance: _____ City: _____ State: _____ Plan #: _____ Group #: _____ Phone: (____) _____ - _____	Rx Card (PBM): _____ PBM BIN: _____ City: _____ State: _____ Group #: _____ Phone: (____) _____ - _____	Cardholder First Name: _____ Last Name: _____ Employer: _____ ID #: _____ Group #: _____
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### 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
<input type="radio"/> Jakafi				

**Physician's Signature:** \_\_\_\_\_ **Date** \_\_\_ / \_\_\_ / \_\_\_

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