SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

The Sentara Health Plans Oncology Program is administered by OncoHealth

- **For any oncology indications**, the most efficient way to submit a prior authorization request is through the **OncoHealth OneUM Provider Portal** at https://oneum.oncohealth.us. Fax to **1-800-264-6128.** OncoHealth can also be contacted by Phone: 1-888-916-2616.
- Commercial customers **NOT** enrolled in the OncoHealth program, please fax requests to Sentara Health plans at fax number 1-800-750-9692.

Drug Requested: Graft-Versus-Host Disease (GVHD) Drugs (select drug below)

❑ **Imbruvica®** (ibrutinib)	❑ **Jakafi®** (ruxolitinib)	❑ **Jakafi XR™** (ruxolitinib)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Maximum Allowable Daily Dosage:

- **Jakafi® and Jakafi XR™ (ruxolitinib):**
  - ❑ Acute & Chronic GVHD: 20 mg per day (immediate release); 22 mg per day (extended release)
- **Imbruvica® (ibrutinib):**
  - ❑ Chronic GVHD: 420 mg per day

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Provider is an oncologist/hematologist
- ❑ **Complete subsequent criteria for the applicable indication below:**

❑ **Diagnosis: Acute Graft-Versus-Host Disease (aGVHD) - Jakafi® and Jakafi XR™** (ruxolitinib) **ONLY**

Initial Authorization: 6 months

- ❑ Medication will be used for disease related to allogeneic hematopoietic stem cell transplantation
- ❑ Members is at least 12 years of age or older
- ❑ Member has acute graft versus host disease (aGVHD) that is refractory to treatment with corticosteroids
- ❑ Provider has submitted recent progress notes and/or clinical assessment recording the symptomology and staging/grading of acute GVHD organ involvement

❑ **Diagnosis: Acute Graft-Versus-Host Disease (aGVHD) - Jakafi® and Jakafi XR™** (ruxolitinib) **ONLY**

Reauthorization: 6 months

- ❑ Member has experienced treatment response as evidenced by stabilization or improvement in disease **(please submit recent progress notes and/or clinical assessment recording improvement in aGVHD organ involvement)**
- ❑ **ONE** of the following must be met:
  - ❑ Member has been able to discontinue therapeutic doses of corticosteroids, **AND** additional therapy authorization will be utilized for tapering ruxolitinib. **NOTE: Taper Jakafi/Jakafi XR by one dose level approximately every 8 weeks per package labeling**
  - ❑ Member requires re-treatment because aGVHD signs/symptoms recurred during or after the tapering of ruxolitinib **(please submit recent progress notes and/or clinical assessment recording changes/worsening of aGVHD organ involvement)**

❑ **Diagnosis: Chronic Graft-Versus-Host Disease (cGVHD) - Jakafi® and Jakafi XR™** (ruxolitinib) **or Imbruvica®** (ibrutinib)

Initial Authorization: 6 months

For Jakafi® IR/XR Requests:

- ❑ Medication will be used for disease related to allogeneic hematopoietic stem cell transplantation
- ❑ Member is at least 12 years of age or older
- ❑ Member has chronic graft versus host disease (cGVHD) that is refractory to treatment with corticosteroids

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- ❑ Member has failed one or two lines of systemic therapy (e.g., mycophenolate, methotrexate) for the treatment of chronic graft versus host disease (cGVHD) **AND** will be used in combination with systemic corticosteroids
- ❑ Provider has submitted recent progress notes and/or clinical assessment recording the symptomology and staging/severity of chronic GVHD (i.e. NIH Global Severity Score, NIH Organ-specific Score)

For Imbruvica® Requests:

- ❑ Medication will be used for disease related to allogeneic hematopoietic stem cell transplantation
- ❑ Member is at least 1 year of age or older
- ❑ Medication will be used as a single agent or in conjunction with systemic steroids
- ❑ Member has failed one or more previous lines of systemic therapy for the treatment of cGVHD (e.g., corticosteroids or immunosuppressant's such as cyclosporine)
- ❑ Provider has submitted recent progress notes and/or clinical assessment recording the symptomology and staging/severity of chronic GVHD (i.e. NIH Global Severity Score, or NIH Organ-specific Score)

❑ **Diagnosis: Chronic Graft-Versus-Host Disease (cGVHD) - Jakafi® and Jakafi XR™ or Imbruvica®** (ibrutinib)

Reauthorization: 6 months

For Jakafi® IR/XR Requests:

- ❑ Member has experienced treatment response as evidenced by stabilization or improvement in disease **[please submit recent progress notes and/or clinical assessment recording the response in symptomology and staging/severity of chronic GVHD (i.e., NIH Global Severity Score, or NIH Organ-specific Score)]**
- ❑ **ONE** of the following must be met:
  - ❑ Member has been able to discontinue therapeutic doses of corticosteroids **AND** additional therapy authorization will be utilized for tapering ruxolitinib. **NOTE: Taper Jakafi/Jakafi XR by one dose level approximately every 8 weeks per package labeling**
  - ❑ Member requires re-treatment because cGVHD signs/symptoms recurred during or after the tapering of ruxolitinib **[please submit recent progress notes and/or clinical assessment recording the response in symptomology and staging/severity of chronic GVHD (i.e., NIH Global Severity Score, or NIH Organ-specific Score)]**

For Imbruvica® Requests:

- ❑ Member has experienced treatment response as evidenced by stabilization or improvement in disease **[please submit recent progress notes and/or clinical assessment recording the response in symptomology and staging/severity of chronic GVHD (i.e. NIH Global Severity Score, or NIH Organ-specific Score)]**

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Medication being provided by Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee**: ~~10/30/2019, 1/10/2022; 11/18/2022;~~ **7/23/2026**
REVISED/UPDATED/REFORMATTED: ~~10/30/2019; 1/10/2022; 2/23/2022; 6/15/2022; 6/16/2022; 11/30/2022; 2/28/2025;~~ **8/28/2026**