SENTARA HEALTH PLANS

MEDICAL 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 1-844-668-1550**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

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

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

❖ **FOR AN ONCOLOGY INDICATION, PLEASE REFER TO THE FOLLOWING PRIOR AUTHORIZATION FORM:**
PAOralOncology.pdf (sitecorecontenthub.cloud)

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

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Maximum Allowable Daily Dosage:

- **Jakafi® (ruxolitinib):**
  - ❑ Acute & Chronic GVHD: 20 mg per day
- **Imbruvica® (ibrutinib):**
  - ❑ Chronic GVHD: 420 mg per day

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® (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® (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 by one dose level approximately every 8 weeks (10 mg twice daily to 5 mg twice daily to 5 mg once daily)**
  - ❑ 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® (ruolitinib) or Imbruvica® (ibrutinib)

Initial Authorization: 6 months

For Jakafi® Requests:

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- ❑ 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
- ❑ 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®** (ruolitinib) **or Imbruvica®** (ibrutinib)

Reauthorization: 6 months

For Jakafi® 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 by one dose level approximately every 8 weeks (10 mg twice daily to 5 mg twice daily to 5 mg once daily)**
  - ❑ 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)]**

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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)]**

Medication being provided by Specialty Pharmacy - PropriumRx

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**
REVISED/UPDATED: ~~10/30/2019; 1/10/2022; 2/23/2022; 6/15/2022; 6/16/2022;~~ **11/30/2022**