

# 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)

**Jakafi®** (ruxolitinib)

**Imbruvica®** (ibrutinib)

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

(Continued on next page)

**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
- Member 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 symptomatology 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® (ruxolitinib) or Imbruvica® (ibrutinib)**

**Initial Authorization: 6 months**

(Continued on next page)

**For Jakafi® 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
- 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)

<input type="checkbox"/> <b>Diagnosis: Chronic Graft-Versus-Host Disease (cGVHD) - Jakafi® (ruxolitinib) or Imbruvica® (ibrutinib)</b>
--

<b><u>Reauthorization: 6 months</u></b>
---

**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)]**

(Continued on next page)

**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 – 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.\****