# OPTIMA HEALTH PLAN

## 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 may be delayed.**

**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:**
**https://www.optimahealth.com/documents/forms/general/paoraloncology.pdf**

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Form/Strength:** _____

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

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

**Weight (within last 30 days:** _____**kg**

**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

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- ❑ 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:**

- ❑ 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)

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❑ **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)]**

**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.****

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

**DEA OR NPI #:** _____

***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**