**Member Name:**

**Date of Birth:**

**Member ID#:**

### Drug Information

**Pharmacy billing (NDC:__________) Start Date (or date of next dose):__________**  
**Dose:__________ Regimen:__________**

### Billing Provider Information

**Pharmacy NPI:**

**Pharmacy Name:**

**Pharmacy Phone:**

**Pharmacy Fax:**

### Prescriber Information

**Prescriber NPI:**

**Prescriber Name:**

**Prescriber Phone:**

**Prescriber Fax:**

**Specialty:**

### Criteria

**For Initial Authorization**

1. Please indicate the diagnosis and information:
   - **Graft-Versus-Host Disease (GVHD)**
     - A. Is diagnosis acute or chronic GVHD? Yes___ No____
     - B. Has the member failed at least 1 prior systemic therapy? Yes___ No____
   - **Myelofibrosis (MF)**
     - A. Will ruxolitinib be used for symptomatic lower-risk MF with no response or loss of response to peginterferon alfa-2a or hydroxyurea? Yes___ No____
     - B. Will ruxolitinib be used for intermediate to high-risk MF? Yes___ No____
   - **Polycythemia Vera**
     - A. Has member had an inadequate response or loss of response to hydroxyurea or peginterferon alfa-2a therapy? Yes___ No____
   - If diagnosis is not listed above, please indicate diagnosis:__________________
   
   **Additional Information:**__________________________________________________________________________________________

**For Continued Authorization:**

1. Date of last dose:______________________________
2. Does member have any evidence of progressive disease while on ruxolitinib? Yes___ No____
3. Has the member experienced adverse drug reactions related to ruxolitinib therapy? Yes___ No____
   If yes, please specify adverse reactions:__________________________________________________________________________________________

### Prescriber Signature:__________________________ Date:________________________

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.  
Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.