



PRIOR AUTHORIZATION REQUEST

REZUROCK

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength:	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL PA requests**. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

- | | | | |
|---|--|-----|----|
| 1 | Is this request for initial therapy or for a continuation of therapy? | | |
| | ☐ Initial (If checked, go to 7) | | |
| | ☐ Continuation (If checked, go to 2) | | |
| 2 | Is the patient currently receiving the requested medication?
[If no, skip to question 7.] | Yes | No |

If you have any
questions, call:
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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the diagnosis or indication? ACTION REQUIRED: Submit supporting documentation. ☐ Acute Graft versus Host Disease (If checked, no further questions) ☐ Chronic Graft versus Host Disease (If checked, go to 8) ☐ Other (If checked, no further questions)		
8	Is the patient 12 years of age or older? [If no, no further questions.]	Yes	No
9	Has the patient had an allogenic hematopoietic cell transplant? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Does the patient have a documented trial and failure with an inadequate response to a systemic corticosteroid with persistent disease progression? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Does the patient have a documented trial and failure with an inadequate response to at least TWO systemic therapies? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include ibrutinib (Imbruvica), ruxolitinib (Jakafi), axatilimab-csfr (Niktimvo), mycophenolate, cyclosporine, etc.] [If no, no further questions.]	Yes	No
12	Will the requested medication be used in combination with ibrutinib (Imbruvica), ruxolitinib (Jakafi), axatilimab-csfr (Niktimvo)?	Yes	No

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[If yes, no further questions.]

- | | | | |
|----|---|-----|----|
| 13 | Does the provider attest that the patient has been evaluated for potential drug-drug interactions and dosing will be adjusted accordingly?
[If no, no further questions.] | Yes | No |
| 14 | Does the provider attest that the patient has been advised of potential reproductive effects and effective contraception therapies have been discussed?
[If no, no further questions.] | Yes | No |
| 15 | Does the patient have documented liver impairment (Child Pugh B or Child Pugh C)? ACTION REQUIRED: Submit supporting documentation.
[If yes, no further questions.] | Yes | No |
| 16 | Does the provider attest that the following labs for the patient will be monitored monthly (total bilirubin, AST, and ALT)?
[If no, no further questions.] | Yes | No |
| 17 | Is the medication prescribed by or in consultation with an oncologist, hematologist, or transplant specialist?
[If no, no further questions.] | Yes | No |
| 18 | Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication?
[Note: Dosing is 200mg orally once daily.] | Yes | No |

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under

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