

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication New or Continuation of Therapy? If continuation, list start date: _____
 Is this patient currently hospitalized? Yes No If recently discharged, list discharge date: _____

Section B - Physician Information

First Name:	Last Name:	M.D./D.O.
Address:		City: State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs
Please refer to www.uhccommunityplan.com for a list of preferred alternatives

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

All Requests:

- **What is the patient's diagnosis? (check all that apply)**

- Primary Myelofibrosis
- Post-Polycythemia Vera Myelofibrosis
- Post-Essential Thrombocythemia Myelofibrosis
- Polycythemia Vera
- Other. List diagnosis: _____

- **Does the patient have a history of failure, inadequate response, contraindication, or intolerance to hydroxyurea?**

Yes No

(If yes, complete Section D above with medication information, including dose, duration, date of trial, and reason for discontinuation)

Requests for Continuation of Therapy:

- **Does the patient have documented evidence of symptom improvement or reduction in spleen volume while on Jakafi?** Yes No

- **Has the patient previously received Jakafi therapy?** Yes No

If yes, list start date: _____ Duration: _____

Physician Signature: _____ **Date:** _____

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Website: uhcommunityplan.com