Prescriber Criteria Form

Inrebic 2026 PA Fax 3162-A v1 010126.docx
Inrebic (fedratinib)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Inrebic (fedratinib).

Drug Name:
Inrebic (fedratinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF)? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of accelerated or blast phase myeloproliferative neoplasm (MPN)? [If yes, then no further questions.]	Yes	No
3	Does the patient have a diagnosis of a myeloid, lymphoid, or mixed lineage neoplasm with eosinophilia and janus kinase 2 (JAK2) rearrangement? [If no, then no further questions.]	Yes	No
4	Is the disease in the chronic or blast phase?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____