

Prescriber Criteria Form

Vonjo 2026 PA Fax 5264-A v1 010126.docx

Vonjo (pacritinib)

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 Vonjo (pacritinib).

Drug Name:  
Vonjo (pacritinib)

**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 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF)? [If no, then skip to question 3.]	Yes	No
2	Does the patient have a platelet count below 50,000 per microliter (mcL)? [No further questions.]	Yes	No
3	Does the patient have a diagnosis of accelerated or blast phase myeloproliferative neoplasms?	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:** \_\_\_\_\_