US Family Health Plan

Prior Authorization Request Form for

Momelotinib (Ojjaara)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID #: _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by or consultation with a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the diagnosis or indication?	☐ Intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis with anemia – proceed to question **6** ☐ Other – proceed to question **4**	
4. Please provide the diagnosis.	_____ Proceed to question **5**	
5. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the provider aware of the warnings, screening, and monitoring precautions for the requested medication?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. What is the patient's gender?	☐ Male **Sign and date below**	☐ Female Proceed to question **8**
8. Is the patient of reproductive potential?	☐ Yes Proceed to question **9**	☐ No **Sign and date below**
9. Will the patient use effective contraception during treatment and for 1 week after the last dose?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has it been confirmed that the patient is not pregnant or is not planning to become pregnant?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the patient avoid breastfeeding during treatment and for at least 1 week after discontinuation?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[8 May 2024]