GUIDELINES FOR USE

1. Does the patient have a diagnosis of polycythemia vera AND meet the following criterion?
   - The patient is 18 years of age or older

   If yes, approve for 12 months by HICL or GPI-10 with a quantity limit of #2mL per 28 days.
   If no, do not approve.

DENIAL TEXT:  *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named ROPEGINTERFERON ALFA-2B-NJFT (Besremi) requires the following rule(s) be met for approval:
A. You have polycythemia vera (a type of blood cancer)
B. You are 18 years of age or older

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE
For further information, please refer to the Prescribing Information and/or Drug Monograph for Besremi.

REFERENCES