TRICARE Prior Authorization Request Form for
niraparib/abiraterone acetate **(Akeega)**

JOHNS HOPKINS
HEALTH PLANS
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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 in consultation with hematologist/oncologist or urologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. For which indication is the requested medication being prescribed?	☐ Deleterious or suspected deleterious BRCA-mutated (BRCAm) metastatic castration-resistant prostate cancer (mCRPC)– proceed to question **4** ☐ Other - proceed to question **7**	
4. Is the patient using the requested medication concurrently with a gonadotropin-releasing hormone (GnRH) analog (for example, leuprolide, Eligard, Triptorelin, Goserelin)?	☐ Yes Proceed to question **6**	☐ No Proceed to question **5**
5. Has the patient had a bilateral orchiectomy?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**

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6. Will the requested medication be used in combination with prednisone?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
7. Please provide the diagnosis.	_____ Proceed to question **8**	
8. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Will male patients with female partners use effective contraception during treatment and for 4 months after the last dose?	☐ Yes - proceed to question **10** ☐ No – **STOP Coverage not approved** ☐ Not applicable - proceed to question **10**	
10. Is the provider aware of the warnings, screening and monitoring precautions for the requested medication?	☐ 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

[14 Feb 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: