Prior Authorization Request Form for
erdafitinib (**Balversa**)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

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.

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 requested medication being prescribed by or in consultation with an oncologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient GREATER THAN or EQUAL TO 18 years of age?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have locally advanced or metastatic urothelial carcinoma that has a susceptible FGFR3 or FGFR2 mutation confirmed with an FDA-approved test?	☐ Yes Proceed to question **4**	☐ No Proceed to question **12**
4. Has the patient progressed during or following at least one line of prior platinum-containing chemotherapy (including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Will the patient be evaluated by an ophthalmologist before starting treatment and every month for the first 4 months, and every 3 months thereafter?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Will the patient be advised to seek emergent evaluation for new ocular symptoms?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Will the patient be monitored for hyperphosphatemia? (*Note that 33% of patients required a phosphate binder in the trial supporting FDA approval for erdafitinib*)	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

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8. Is the patient male or female?	☐ Male Proceed to question **11**	☐ Female Proceed to question **9**
9. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Is the patient breastfeeding?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **11**
11. Will patients with reproductive potential use highly effective contraception during treatment and for 1 month after the last dose?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
12. Please provide the diagnosis.	_____ Proceed to question **13**	
13. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ 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

[13 November 2019]

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