Prior Authorization Request Form for
zanubrutinib **(Brukinsa)**

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

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

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 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 prescribed by or in consultation with a hematologist/oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. For which indication is the requested medication being prescribed?	☐ **Pathologically confirmed relapsed or refractory mantle cell lymphoma (MCL)** – Proceed to question **6** ☐ **Other** – Proceed to question **4**	
4. Please provide the indication or 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. Will the patient be monitored for bleeding, infection (including opportunistic infection), cardiac arrhythmias, secondary primary malignancies, and cytopenias?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. Will the patient use sun protection in sun-exposed areas?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. What is the age/gender of the patient?	☐ **Male** - **Sign and date below** ☐ **Female of childbearing age** – Proceed to question **9** ☐ **Female not of childbearing age** - **Sign and date below**	
9. Has it been confirmed that the patient is not pregnant by (-) negative HCG?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has it been confirmed that the patient will not breastfeed during treatment and for at least 2 weeks after the cessation of treatment?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient agree to use effective contraception during treatment and for at least 1 week after the cessation of treatment?	☐ 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 May 2020]

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