Prior Authorization Request Form for
duvelisib (**Copiktra**)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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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.

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 a hematologist/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. For which indication is the requested medication being prescribed?	☐ relapsed or refractory chronic lymphocytic leukemia (CLL) - proceed to question **4** ☐ relapsed or refractory small lymphocytic lymphoma (SLL) - proceed to question **4** ☐ relapsed or refractory follicular lymphoma (FL) - proceed to question **4** ☐ marginal zone lymphoma (MZL) - proceed to question **5** ☐ Other: proceed to question **6**	
4. Has the patient undergone at least two prior systemic therapies?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the diagnosis been pathologically confirmed?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**

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6. Please provide the diagnosis.	_____ Proceed to question **7**	
7. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the provider aware and has informed patient of the risk of serious, life-threatening, and fatal infections, including Pneumocystis jiroveci pneumonia (PJP) and cytomegalovirus (CMV); diarrhea; colitis; cutaneous reactions, including drug rash with eosinophilia and systemic symptoms (DRESS) and Stevens Johnson Syndrome spectrum reactions, including Toxic Epidermal Necrolysis; pneumonitis; hepatotoxicity; and neutropenia?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have evidence of active infection, diarrhea, colitis, serious cutaneous disease, pneumonitis, hepatitis, significantly elevated liver-associated enzymes, or neutropenia?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **10**
10. What is the patient's age/gender?	☐ **Male** - proceed to question **14** ☐ **Female of childbearing age** - proceed to question **11** ☐ **Female not of childbearing age** - proceed to question **16**	
11. Has it been confirmed that the patient is not pregnant by a negative HCG test?	☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Does the patient agree to use contraception during treatment and for at least 1 month after the cessation of treatment?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Does the patient agree to not breastfeed during treatment and for at least 1 month after the cessation of treatment?	☐ Yes proceed to question **16**	☐ No **STOP** **Coverage not approved**

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14. Do male patients with female partners agree to use contraception during treatment and for at least 1 month after the cessation of treatment?	☐ Yes proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Are patients informed that Copiktra may cause male infertility?	☐ Yes proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Is the prescriber enrolled in Copiktra REMS program?	☐ 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

[08 April 2020]

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