TRICARE Prior Authorization Request Form for
glasdegib (**Daurismo**)

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. Has the patient been newly diagnosed with acute myeloid leukemia?	☐ Yes Proceed to question **2**	☐ No Proceed to question **6**
2. Is this medication being prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Will this medication be used in combination with low-dose cytarabine?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Is the patient 75 years of age or older?	☐ Yes Proceed to question **8**	☐ No Proceed to question **5**
5. Does the patient have comorbidities that preclude use of intensive induction chemotherapy?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved
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. Does the provider acknowledge and has the patient been informed that limitations of use include that this drug has not been studied in patients with severe renal impairment or moderate to severe hepatic impairment?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved

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9. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **10**
10.Will the patient be monitored for febrile neutropenia and QTc prolongation?	☐ 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

[29 May 2019]

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