

TRICARE Prior Authorization Request Form for
givinostat (**Duvyzat**)



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.

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 6 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the requested medication prescribed by a neurologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Does the patient have a diagnosis of Duchenne Muscular Dystrophy (DMD) that has been confirmed by genetic testing or muscle biopsy?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Is the patient ambulatory?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Does the patient have a contraindication to, intolerability to, or has failed a trial of deflazacort (Emflaza)?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Does the provider acknowledge the FDA safety alerts, warnings, precautions, drug interactions, and monitoring recommendations for the requested medication?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

_____	_____
Prescriber Signature	Date

For Internal Use Only Approved:

Duration of Approval: ____month(s)

 Denied:

Authorized By:

 Incomplete/Other:

PA#:

Date Faxed to MD:

Date Decision Rendered: