TRICARE Prior Authorization Request Form for
panobinostat **(Farydak)**

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. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for*	☐ Yes (subject to verification) **Proceed to question 14**	☐ No **Proceed to question 2**
2. Is the requested medication being prescribed by or in consultation with a hematologist or oncologist?	☐ Yes **Proceed to question 3**	☐ No **STOP** **Coverage not approved**
3. Is the patient GREATER THAN or EQUAL to 18 years of age?	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**
4. For which indication is the requested medication being prescribed?	☐ Relapsed or refractory multiple myeloma - **Proceed to question 5roceed to question 5** ☐ Other - **Proceed to question 16**	
5. Is the patient's disease refractory to all of the following drugs: • **bortezomib (Velcade),** • **carfilzomib (Kyprolis),** • **ixazomib (Ninlaro)?**	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 6**
6. Will the patient be starting Farydak as the third (or higher) line of therapy?	☐ Yes **Proceed to question 7**	☐ No **STOP** **Coverage not approved**

7. Does the patient's previous regimens include at least one regimen with bortezomib, carfilzomib OR ixazomib?	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**
8. Does the patient's previous regimens include at least one regimen with lenalidomide, pomalidomide, OR thalidomide?	☐ Yes **Proceed to question 9**	☐ No **STOP** **Coverage not approved**
9. Will Farydak be used in conjunction with dexamethasone?	☐ Yes **Proceed to question 10**	☐ No **STOP** **Coverage not approved**
10. Will Farydak be used in conjunction with a bortezomib, carfilzomib, OR Ninlaro-containing regimen?	☐ Yes **Proceed to question 11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have a platelet count greater than 100x10^9/L?	☐ Yes **Proceed to question 12**	☐ No **STOP** **Coverage not approved**
12. Is the patient's QTc less than 450 msec?	☐ Yes **Proceed to question 13**	☐ No **STOP** **Coverage not approved**
13. Is there evidence of acute or chronic ischemic disease on EKG and no history of MI or unstable angina within the last 6 months?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 14**
14. Does the patient have access to anti-diarrheal therapy?	☐ Yes – Initial therapy – **Sign and date below** ☐ Yes – Continuation of therapy – **Proceed to question 15** ☐ No – **STOP Coverage not approved**	
15. Has the patient completed 16 cycles of treatment?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
16. Please provide the diagnosis.	_____ **Proceed to question 17**	
17. 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

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