TRICARE Prior Authorization Request Form for
enasidenib **(Idhifa) and** ivosidenib **(Tibsovo)**

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.

Prior authorization for Idhifa will expire in 1 year. Prior authorization for Tibsovo is indefinite.

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 being prescribed by or in consultation with hematologist or oncologist?	☐ Yes **Proceed to question 3**	☐ No **STOP Coverage not approved**
3. For which medication is coverage being requested?	☐ Idhifa **Proceed to question 4**	☐ Tibsovo **Proceed to question 11**
4. Does the patient have a diagnosis of relapsed or refractory acute myelogenous leukemia (AML)?	☐ Yes **Proceed to question 5**	☐ No **Proceed to question 9**
5. Does the patient exhibit the IDH2 mutation as determined by an FDA approved test?	☐ Yes **Proceed to question 6**	☐ No **Proceed to question 9**
6. 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 Idhifa.*	☐ Yes **Proceed to question 7**	☐ No **Proceed to question 8**
7. Has the patient experienced disease progression?	☐ Yes **STOP Coverage not approved**	☐ No **Sign and date on next page**

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8. Will the requested medication be used in combination with standard chemotherapy protocols?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
9. Please provide the diagnosis.	_____ Proceed to question **10** **Please provide the diagnosis.**	
10. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B	☐ Yes **Sign and date below**	☐ No **STOP coverage not approved**
11. Does the patient have a diagnosis of relapsed/refractory acute myeloid leukemia (AML) with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation as detected by a FDA-approved test?	☐ Yes **Proceed to question 19**	☐ No **Proceed to question 12**
12. Has the patient been newly diagnosed with acute myelogenous leukemia (AML)?	☐ Yes **Proceed to question 13**	☐ No **Proceed to question 16**
13. Is the patient using Tibsovo as monotherapy OR in combination with azacitidine (Vidaza)?	☐ Yes **Proceed to question 14**	☐ No **Proceed to question 16**
14. Is the patient GREATER THAN or EQUAL TO 75 years of age?	☐ Yes **Proceed to question 19**	☐ No **Proceed to question 15**
15. Does the patient have comorbidities that preclude use of intensive induction chemotherapy with a susceptible IDH1 mutation as detected by a FDA-approved test?	☐ Yes **Proceed to question 19**	☐ No **Proceed to question 16**
16. Does the patient have previously treated, locally advanced, or metastatic cholangiocarcinoma with an IDH1 mutation as detected by a FDA-approved test?	☐ Yes **Proceed to question 19**	☐ No **Proceed to question 17**
17. Please provide the diagnosis.	_____ Proceed to question **18**	
18. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B	☐ Yes **Proceed to question 19**	☐ No **STOP** **Coverage not approved**
19. Will the patient be monitored for differentiation syndrome?	☐ Yes **Proceed to question 20**	☐ No **STOP** **Coverage not approved**

20. Will the patient be monitored for Guillain-Barre Syndrome?	☐ 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 _____

[05 April 2023]

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