

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



**JOHNS HOPKINS**  
HEALTH PLANS

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 <b>GREATER THAN</b> or <b>EQUAL TO</b> 18 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
2. Is the requested medication being prescribed by or in consultation with hematologist or oncologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
3. For which medication is coverage being requested?	<input type="checkbox"/> Idhifa Proceed to question 4	<input type="checkbox"/> Tibsovo Proceed to question 11
4. Does the patient have a diagnosis of relapsed or refractory acute myelogenous leukemia (AML)?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Proceed to question 9
5. Does the patient exhibit the IDH2 mutation as determined by an FDA approved test?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No Proceed to question 9
6. Has the patient received this medication under the TRICARE benefit in the last 6 months? <i>Please choose "No" if the patient did not previously have a TRICARE approved PA for Idhifa.</i>	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No Proceed to question 8
7. Has the patient experienced disease progression?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Sign and date on next page

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<p>8. Will the requested medication be used in combination with standard chemotherapy protocols?</p>	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>9. Please provide the diagnosis.</p>	<p>-----</p> <p>Proceed to question 10 Please provide the diagnosis.</p>	
<p>10. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B</p>	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No <b>STOP coverage not approved</b></p>
<p>11. Does the patient have a susceptible isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA-approved test?</p>	<p><input type="checkbox"/> Yes Proceed to question 12</p>	<p><input type="checkbox"/> No <b>STOP coverage not approved</b></p>
<p>12. Does the patient have a diagnosis of relapsed/refractory acute myeloid leukemia (AML)?</p>	<p><input type="checkbox"/> Yes Proceed to question 21</p>	<p><input type="checkbox"/> No Proceed to question 13</p>
<p>13. Has the patient been newly diagnosed with acute myelogenous leukemia (AML)?</p>	<p><input type="checkbox"/> Yes Proceed to question 14</p>	<p><input type="checkbox"/> No Proceed to question 17</p>
<p>14. Is the patient using Tibsovo as monotherapy OR in combination with azacitidine (Vidaza)?</p>	<p><input type="checkbox"/> Yes Proceed to question 15</p>	<p><input type="checkbox"/> No Proceed to question 17</p>
<p>15. Is the patient GREATER THAN or EQUAL TO 75 years of age?</p>	<p><input type="checkbox"/> Yes Proceed to question 21</p>	<p><input type="checkbox"/> No Proceed to question 16</p>
<p>16. Does the patient have comorbidities that preclude use of intensive induction chemotherapy?</p>	<p><input type="checkbox"/> Yes Proceed to question 21</p>	<p><input type="checkbox"/> No Proceed to question 17</p>
<p>17. Does the patient have previously treated, locally advanced, or metastatic cholangiocarcinoma?</p>	<p><input type="checkbox"/> Yes Proceed to question 21</p>	<p><input type="checkbox"/> No Proceed to question 18</p>
<p>18. Does the patient have relapsed or refractory myelodysplastic syndrome (MDS)?</p>	<p><input type="checkbox"/> Yes Proceed to question 21</p>	<p><input type="checkbox"/> No Proceed to question 19</p>
<p>19. Please provide the diagnosis.</p>	<p>-----</p> <p>Proceed to question 20</p>	
<p>20. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B</p>	<p><input type="checkbox"/> Yes Proceed to question 21</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>

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21. Will the patient be monitored for differentiation syndrome?	<input type="checkbox"/> Yes <b>Proceed to question 22</b>	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>
22. Will the patient be monitored for Guillain-Barre Syndrome?	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>

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

\_\_\_\_\_ Prescriber Signature

\_\_\_\_\_ Date

[26 June 2024]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: