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. 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 a hematologist/oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Will Inrebic be used for intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis?	☐ Yes Proceed to question **6**	☐ No Proceed to question **4**
4. Please provide the diagnosis.	_____ Proceed to question **5**	
5. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Provider acknowledges that serious and fatal encephalopathy including Wernicke's encephalopathy has occurred in patients treated with Inrebic. If thiamine deficiency is expected or confirmed, Inrebic should be discontinued immediately and the patient should receive emergent parenteral thiamine?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Does the patient have vitamin B1 deficiency?	☐ No **STOP** **Coverage not approved**	☐ Yes Proceed to question **8**

8. Will the following labs be assessed prior to starting Inrebic and periodically while the patient is taking the requested medication: thiamine (Vitamin B1), CBC with platelets, serum creatinine and BUN, hepatic panel and amylase and lipase?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Will nutritional status will be assessed prior to starting Inrebic and periodically while the patient is taking the requested medication?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. What is the patient's age/gender?	☐ Male – proceed to question **14** ☐ Female of reproductive age – proceed to question **11** ☐ Female NOT of reproductive age – **Sign and date below**	
11. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Is the patient breast-feeding?	☐ Yes Proceed to question **13**	☐ No Proceed to question **14**
13. Will the patient refrain from breastfeeding during treatment and for 1 month after cessation of treatment?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Will the patient take effective contraception during treatment and for 1 month after discontinuation?	☐ 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

[19 February 2020]

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