Prior Authorization Request Form for

inavolisib (Itovebi)

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.

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 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the requested medication being prescribed by or in consultation with an oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. What is the indication or diagnosis?	☐ Locally advanced or metastatic hormone receptor (HR)-positive disease- Proceed to question **4** ☐ Human epidermal growth factor receptor 2 (HER2)-negative disease - Proceed to question **4** ☐ PIK3CA-mutated breast cancer as detected by an FDA approved test - Proceed to question **4** ☐ Disease recurrence on or after completing adjuvant endocrine therapy - Proceed to question **4** ☐ Other diagnosis - Proceed to question **5**	
4. Will the requested medication be used in combination with Ibrance (palbociclib capsules and tablets) AND fulvestrant injection?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

5. The diagnosis IS NOT listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. **To facilitate approval, please list the diagnosis, guideline version, and page number:**	_____ **Sign and date below**

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: