Prior Authorization Request Form for

ziftomenib (Komzifti)

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.

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?	☐ Relapsed or refractory acute myeloid leukemia - Proceed to question **4** ☐ Other diagnosis - Proceed to question **6**	
4. Does the patient have a susceptible NPM1-mutation with no satisfactory alternative treatment options?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have concomitant KMT2A gene translocation?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
6. 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: