TRICARE Prior Authorization Request Form for
olaparib **(Lynparza)**

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 requested medication being prescribed by or in consultation with a hematologist/oncologist or urologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the requested medication being used as treatment or maintenance therapy?	☐ Treatment Proceed to question **4**	☐ Maintenance Proceed to question **12**
4. Will the requested medication be used as treatment for one or more of the following diagnoses?	☐ Recurrent or Stage IV Triple negative breast cancer - Proceed to **11** ☐ Recurrent or Stage IV hormone receptor positive (ER, PR, or both) HER2 negative breast cancer – Proceed to **5** ☐ Recurrent advanced ovarian cancers (platinum-sensitive or platinum resistant), fallopian tube or primary peritoneal cancers – Proceed to **9** ☐ Deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene (for example, BRCA, ATM)-mutated metastatic castration-resistant prostate cancer (mCRPC) – proceed to **7** ☐ Deleterious or suspected deleterious gBRCam, (HER2)-negative, high-risk early breast cancer – Proceed to **8** ☐ Deleterious or suspected deleterious BRCA-mutated (BRCAm) metastatic castration-resistant prostate cancer (mCRPC) – Proceed to **18** ☐ Other indication or diagnosis – Proceed to **24**	

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5. Has the patient been previously treated with prior endocrine therapy?	☐ Yes Proceed to question **11**	☐ No Proceed to question **6**
6. Is the patient an inappropriate candidate for endocrine therapy?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
7. Has the patient progressed following prior androgen receptor-directed therapy (for example, abiraterone or enzalutamide)?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**
8. Has the patient been treated with neoadjuvant or adjuvant chemotherapy?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
9. Has the patient received at least 3 prior lines of therapy?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Will the requested medication be used as a single agent?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **11**
11. Does the patient have a deleterious or suspected deleterious BRCA mutation as detected by an FDA-approved test?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**
12. Will the patient use the requested medication as a maintenance therapy for one of the following diagnoses?	☐ Platinum-sensitive, **relapsed**, epithelial ovarian cancer, fallopian tube or primary peritoneal cancer- Proceed to **13** ☐ Newly diagnosed, advanced, high-grade, epithelial ovarian cancer, fallopian tube or primary peritoneal cancer– Proceed to **15** ☐ Metastatic pancreatic adenocarcinoma – Proceed to **16** ☐ Other indication or diagnosis – Proceed to **24**	
13. Has the patient received 2 or more lines of platinum-based chemotherapy?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Was the patient objective in response (either complete or partial) to the most recent treatment regimen?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**
15. Has the patient had a complete or partial response to primary therapy with a platinum-based therapy?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**

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16. Has the disease progressed on at least 16 weeks of a first-line platinum-based chemotherapy regimen?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **19**
17. Will the requested medication be combined with bevacizumab (Avastin)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **19**
18. Will the requested medication be used in combination with abiraterone AND prednisone OR prednisolone?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**
19. What is the patient's age/gender?	☐ **Male** - proceed to question **23** ☐ **Female of childbearing age** - proceed to question **20** ☐ **Female not of childbearing age** - Sign and date below	
20. Will the patient take highly effective contraception while taking the requested medication and for 6 months after the last dose?	☐ Yes Proceed to question **21**	☐ No **STOP** **Coverage not approved**
21. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **22**
22. Will the patient avoid breastfeeding during treatment or within one month after the cessation of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
23. Will the patient use effective contraception while taking the requested medication and for at least 3 months after cessation of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
24. Please provide the diagnosis.	_____ **Proceed to question 25**	
25. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **26**	☐ No **STOP** **Coverage not approved**
26. What is the patient's age/gender?	☐ **Male** - proceed to question **30** ☐ **Female of childbearing age** - proceed to question **27** ☐ **Female not of childbearing age - Sign and date below**	
27. Will the patient take highly effective contraception while taking the requested medication and for 6 months after the last dose?	☐ Yes Proceed to question **28**	☐ No **STOP** **Coverage not approved**

28. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **29**
29. Will the patient avoid breastfeeding during treatment or within one month after the cessation of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
30. Will the patient use effective contraception while taking the requested medication and for at least 3 months after cessation of therapy?	☐ 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

[3 January 2024]

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