

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):

1 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?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Is the requested medication being used as treatment or maintenance therapy?	<input type="checkbox"/> Treatment Proceed to question 4	<input type="checkbox"/> Maintenance Proceed to question 12
4. Will the requested medication be used as treatment for one or more of the following diagnoses?	<input type="checkbox"/> Recurrent or Stage IV Triple negative breast cancer - Proceed to 11 <input type="checkbox"/> Recurrent or Stage IV hormone receptor positive (ER, PR, or both) HER2 negative breast cancer – Proceed to 5 <input type="checkbox"/> Recurrent advanced ovarian cancers (platinum-sensitive or platinum resistant), fallopian tube or primary peritoneal cancers – Proceed to 9 <input type="checkbox"/> 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 <input type="checkbox"/> Deleterious or suspected deleterious gBRCAm, (HER2)-negative, high-risk early breast cancer – Proceed to 8 <input type="checkbox"/> Deleterious or suspected deleterious BRCA-mutated (BRCAm) metastatic castration-resistant prostate cancer (mCRPC) – Proceed to 18 <input type="checkbox"/> Other indication or diagnosis – Proceed to 24	

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5. Has the patient been previously treated with prior endocrine therapy?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No Proceed to question 6
6. Is the patient an inappropriate candidate for endocrine therapy?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No STOP Coverage not approved
7. Has the patient progressed following prior androgen receptor-directed therapy (for example, abiraterone or enzalutamide)?	<input type="checkbox"/> Yes Proceed to question 19	<input type="checkbox"/> No STOP Coverage not approved
8. Has the patient been treated with neoadjuvant or adjuvant chemotherapy?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No STOP Coverage not approved
9. Has the patient received at least 3 prior lines of therapy?	<input type="checkbox"/> Yes Proceed to question 10	<input type="checkbox"/> No STOP Coverage not approved
10. Will the requested medication be used as a single agent?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 11
11. Does the patient have a deleterious or suspected deleterious BRCA mutation as detected by an FDA-approved test?	<input type="checkbox"/> Yes Proceed to question 19	<input type="checkbox"/> No STOP Coverage not approved
12. Will the patient use the requested medication as a maintenance therapy for one of the following diagnoses?	<input type="checkbox"/> Deleterious or suspected deleterious germline or somatic BRCA-mutated recurrent epithelial ovarian, fallopian tube or peritoneal cancer – Proceed to 13 <input type="checkbox"/> Newly diagnosed, advanced, high-grade, epithelial ovarian cancer, fallopian tube or primary peritoneal cancer– Proceed to 15 <input type="checkbox"/> Metastatic pancreatic adenocarcinoma – Proceed to 16 <input type="checkbox"/> Other indication or diagnosis – Proceed to 24	
13. Has the patient received 2 or more lines of platinum-based chemotherapy?	<input type="checkbox"/> Yes Proceed to question 14	<input type="checkbox"/> No STOP Coverage not approved
14. Was the patient objective in response (either complete or partial) to the most recent treatment regimen?	<input type="checkbox"/> Yes Proceed to question 17	<input type="checkbox"/> No STOP Coverage not approved
15. Has the patient had a complete or partial response to primary therapy with a platinum-based therapy?	<input type="checkbox"/> Yes Proceed to question 19	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 19
17. Will the requested medication be combined with bevacizumab (Avastin)?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 19
18. Will the requested medication be used in combination with abiraterone AND prednisone OR prednisolone?	<input type="checkbox"/> Yes Proceed to question 19	<input type="checkbox"/> No STOP Coverage not approved
19. What is the patient's age/gender?	<input type="checkbox"/> Male - proceed to question 23 <input type="checkbox"/> Female of childbearing age - proceed to question 20 <input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to question 21	<input type="checkbox"/> No STOP Coverage not approved
21. Is the patient pregnant or actively trying to become pregnant?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 22
22. Will the patient avoid breastfeeding during treatment or within one month after the cessation of therapy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to question 26	<input type="checkbox"/> No STOP Coverage not approved
26. What is the patient's age/gender?	<input type="checkbox"/> Male - proceed to question 30 <input type="checkbox"/> Female of childbearing age - proceed to question 27 <input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to question 28	<input type="checkbox"/> No STOP Coverage not approved

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28. Is the patient pregnant or actively trying to become pregnant?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 29
29. Will the patient avoid breastfeeding during treatment or within one month after the cessation of therapy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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

[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: