TRICARE Prior Authorization Request Form for
mifepristone 200 mg tablets **(Mifeprex)**

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.

PA renewal is not allowed; no refills allowed; each course of therapy requires a new PA

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. Are the patient and provider enrolled in the Mifeprex Risk Evaluation and Mitigation Strategies (REMS) program?	☐ Yes **Proceed to question 2**	☐ No **STOP** **Coverage not approved**
2. What is the indication or diagnosis?	☐ **Termination of pregnancy - Proceed to question 3** ☐ **Pregnancy loss - Proceed to question 9** ☐ **Other – STOP Coverage not approved**	
3. Is the patient terminating a pregnancy through 70 days of gestation?	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**
4. Please document the date of the patient's last menstrual period and anticipated date of treatment initiation. **Date of the patient's last menstrual period: _____** **Anticipated date of treatment initiation: _____** **Proceed to question 5**		
5. Is the patient seeking to terminate pregnancy due to an act of rape or incest?	☐ Yes **Proceed to question 6**	☐ No **Proceed to question 7**
6. Is it the provider's good faith belief, based on all of the information available to the provider, that the patient was the victim of rape or incest? (The provider should maintain medical records that support the provider's good faith belief).	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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7. Is the patient seeking to terminate pregnancy because the patient's life would be endangered by carrying the fetus to term?	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**
8. Does the provider certify that the mother's life would be at risk if the fetus was carried to term? (The provider should maintain medical records that support the provider's certification).	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
9. Has the patient experienced a pregnancy loss and requests medical management?	☐ Yes **Proceed to question 10**	☐ No **STOP** **Coverage not approved**
10. Does the provider certify that the medication will be used to manage a pregnancy loss and will not be used for termination of a pregnancy (medical abortion)? (The provider should maintain medical records that support the provider's certification).	☐ 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

[31 May 2023]

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