Prior Authorization Request Form for

dordaviprone hcl (Modeyso)

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 prescribed by a hematologist or oncologist?	☐ Yes Proceed to Question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient 1 year of age or older?	☐ Yes Proceed to Question **3**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis?	☐Diffuse midline glioma (DMG) – Proceed to question **4** ☐Other – Proceed to question **7**	
4. Does the patient have a histone 3 (H3) K27M mutation?	☐ Yes Proceed to Question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a progressive disease?	☐ Yes Proceed to Question **6**	☐ No **STOP** **Coverage not approved**

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6. Has the patient received AT LEAST ONE prior therapy? ***Note: Examples of prior therapy include radiation, temozolomide, procarbazine, lomustine, or vincristine.***	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
7. 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

[10 September 2025]

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