Prior Authorization Request Form for
ixazomib **(Ninlaro)**

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.

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 patient GREATER THAN or EQUAL to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the requested medication being prescribed by or consultation with a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Does the patient have a diagnosis of multiple myeloma?	☐ Yes Proceed to question **4**	☐ No Proceed to question **11**
4. Has the patient had disease progression while on a bortezomib (Velcade) or a carfilzomib (Kyprolis) - containing regimen?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **5**
5. Has the patient had adverse drug reactions/ adverse drug event/ allergy or is not a candidate for bortezomib AND carfilzomib?	☐ Yes Proceed to question **8**	☐ No Proceed to question **6**
6. Has the patient had adverse drug reactions/ adverse drug event/ allergy or is not a candidate for carfilzomib and has high risk cytogenetics?	☐ Yes Proceed to question **8**	☐ No Proceed to question **7**
7. Will the patient be starting Ninlaro as the third (or higher) line of therapy?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved

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8. Will the requested medication be used in combination with lenalidomide (Revlimid), pomalildomide (Pomalyst), OR thalidomide (Thalomid)?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
9. Will the requested medication be used in combination with dexamethasone?	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
10. Will the patient be using the requested medication concurrently with bortezomib or carfilzomib?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**
11. Please provide the diagnosis.	_____ Proceed to question **12**	
12. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ 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

[14 August 2019]

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