Prior Authorization Request Form for azacitidine (Onureg)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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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 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication prescribed by or in consultation with a hematologist/oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. For which indication or diagnosis is the requested medication being prescribed?	☐ Myelodysplastic syndromes (MDS) – **STOP Coverage not approved** ☐ Maintenance therapy of acute myeloid leukemia (AML) - Proceed to question **4** ☐ Other - Proceed to question **7**	
4. Will the patient use the requested medication following complete remission (CR) achieved after intensive induction chemotherapy with or without consolidation therapy?	☐ Yes Proceed to question **6**	☐ No Proceed to question **5**
5. Will the patient use the requested medication following complete remission with incomplete blood count recovery (CRi) achieved after intensive induction chemotherapy with or without consolidation therapy?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Will the patient be able to complete intensive curative therapy?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**

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7. Please provide the indication or diagnosis.	_____ Proceed to question **8**	
8. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Will the requested medication be used for parenteral routes of administration?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Does the provider agree to monitor for myelosuppression/cytopenias?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Is the patient of childbearing potential?	☐ Yes Proceed to question **12**	☐ No **Sign and date below**
12. What is the patient's gender?	☐ Male – Proceed to question **13** ☐ Female – Proceed to question **14**	
13. Will the patient use effective contraception during treatment and for at least 3 months after the cessation of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
14. Will the patient use effective contraception during treatment and for at least 6 months after the cessation of therapy?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **16**
16. Has it been confirmed that the patient is not pregnant by (-) HCG?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. Will the patient not breastfeed during treatment and for at least 1 week after the cessation of treatment?	☐ 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

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