Prior Authorization Request Form for
alpelisib (**Piqray**)

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 requested medication being prescribed by or in consultation with an oncologist /hematologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient GREATER THAN or EQUAL TO 18 years of age?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient been diagnosed with advanced or metastatic HR positive, HER2 negative breast cancer with PIK3CA mutation as confirmed by an FDA-approved test?	☐ Yes Proceed to question **4**	☐ No Proceed to question **15**
4. Is the patient female?	☐ Yes Proceed to question **5**	☐ No Proceed to question **8**
5. Is the patient post-menopausal or pre-menopausal?	☐ Post-menopausal Proceed to question **9**	☐ Pre-menopausal Proceed to question **6**
6. Is the patient receiving ovarian ablation/suppression?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Will the patient use effective contraception during therapy and for one week after the last dose?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**

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8. Will the patient use condoms and effective contraception during therapy and for one week after last dose?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient tried and failed, or is not a candidate for, adjuvant or neoadjuvant chemotherapy?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the patient had disease progression while on or after endocrine-based therapy?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the patient receive fulvestrant injection (Faslodex) therapy along with alpelisib (Piqray)?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Does the patient have a history of Stevens Johnson Syndrome, Erythema Multiforme, or Toxic Epidermal Necrolysis?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **13**
13. Is the provider aware and has informed patient of risk of serious, life-threatening skin reactions, including Stevens Johnson Syndrome; severe hyperglycemia; gastrointestinal toxicity, including severe diarrhea; kidney injury; lung injury including pneumonitis; pancreatitis; and severe hypersensitivity reactions?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Is the provider aware and has informed the patient that safety has not been established in type 1 or uncontrolled type 2 diabetic patients?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
15. Please provide the diagnosis.	_____ Proceed to question **16**	
16. 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

[13 November 2019]

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