

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	Please complete patient and physician information (please print):			
1	Patient	Name: Physic	Physician Name:	
	Addres		Address:	
	Sponso		Phone #:	
	Date of	f Birth: See	cure Fax #:	
Step	Step Please complete the clinical assessment:			
2	1.	Is the requested medication being prescribed by or in consultation with an oncologist /hematologist?	□ Yes	□ No
			Proceed to question 2	STOP
				Coverage not approved
	2.	Is the patient GREATER THAN or EQUAL TO 18 years of age?	□ Yes	🗆 No
		or age:	Proceed to question 3	STOP
				Coverage not approved
	3.	······································	□ Yes	🗆 No
		metastatic HR positive, HER2 negative breast cancer with PIK3CA mutation as confirmed by an FDA- approved test?	Proceed to question 4	Proceed to question 15
	4.	Is the patient female?	□ Yes	🗆 No
			Proceed to question 5	Proceed to question 8
	5.	Is the patient post-menopausal or pre-menopausal?	Post-menopausal	Pre-menopausal
			Proceed to question 9	Proceed to question 6
	6.	Is the patient receiving ovarian ablation/suppression?	□ Yes	🗆 No
			Proceed to question 7	STOP
				Coverage not approved
	7.	Will the patient use effective contraception during	□ Yes	□ No
		therapy and for one week after the last dose?	Proceed to question 9	STOP
				Coverage not approved

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

8. Will the patient use condoms and effective contraception during therapy and for one week after last dose? Image: Contrace picture duestion 9 Image: Contrace picture duestion 9 9. Has the patient tried and failed, or is not a candidate for, adjuvant or neoadjuvant chemotherapy? Image: Contrace picture duestion 10 Image: Contrace picture duestion 10 Image: Contrace picture duestion 10 STOP 10. Has the patient had disease progression while on or after endocrine-based therapy? Image: Contrace picture duestion 10 STOP Coverage not approved 11. Will the patient receive fulvestrant injection (Faslodex) therapy along with alpelisib (Piqray)? Image: Coverage not approved Image: Coverage not approved 12. Does the patient have a history of Stevens Johnson Syndrome, Erythema Multiforme, or Toxic Epidermal Necrolysis? Image: Coverage not approved Image: Coverage not approved 13. Is the provider aware and has informed patient of risk of serious, life-threatening skin reactions, including severe durine; kidney nipury: lung inpury including pneumonitis; pancreatitis; and severe hypersensitivity reactions? Image: Coverage not approved Image: Coverage not approved 14. Is the provider aware and has informed the patient that affer the entestablished in type 1 or uncontrolled type 2 diabetic patients? Image: Coverage not approved Image: Coverage not approved 15. Please provide the diagnosis. Image: Coverage not approved Image: Coverage not approved Image: Coverage not ap			
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Coverage not approved		Sign and date below	STOP
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Step I certify the above is true to the best of my knowledge. Please sign and date:

3

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: