Prior Authorization Request Form for ripretinib (Qinlock)

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:**

Question		
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 or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have pathologically confirmed advanced gastrointestinal stromal tumor (GIST)?	☐ Yes Proceed to question **6**	☐ No Proceed to question **4**
4. Please provide the indication or diagnosis.	______________________ Proceed to question **5**	
5. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Has the patient experienced disease progression on imatinib (Gleevec)?	☐ Yes Proceed to question **8**	☐ No Proceed to question **7**

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Question	Yes	No
7. Has the patient had documented intolerance to imatinib (Gleevec)?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient experienced disease progression on sunitinib (Sutent)?	☐ Yes Proceed to question **10**	☐ No Proceed to question **9**
9. Has the patient had documented intolerance to sunitinib (Sutent)?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the patient experienced disease progression on regorafenib (Stivarga)?	☐ Yes Proceed to question **12**	☐ No Proceed to question **11**
11. Has the patient had documented intolerance to regorafenib (Stivarga)?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Is the patient of childbearing potential?	☐ Yes Proceed to question **13**	☐ No **Sign and date below**
13. What is the patient's gender?	☐ Male – Proceed to question **14** ☐ Female – Proceed to question **15**	
14. Will the patient use effective contraception during treatment and for at least 6 weeks after the cessation of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
15. Will the patient use effective contraception during treatment and for at least 6 weeks after the cessation of therapy?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **17**
17. Has it been confirmed that the patient is not pregnant by (-) HCG?	☐ Yes Proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Will the patient not breastfeed during treatment and for at least 2 weeks 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

[11 November 2020]

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