Prior Authorization Request Form for

revumenib (Revuforj)

JOHNS HOPKINS
HEALTH PLANS
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.

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Please complete the clinical assessment:

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1. Is the requested medication being prescribed by or in consultation with an oncologist?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. What is the indication or diagnosis?	☐ Relapsed or refractory acute leukemia- Proceed to question **3** ☐ Relapsed or refractory acute myeloid leukemia - Proceed to question **4** ☐ Other diagnosis - Proceed to question **5**	
3. Is the disease positive for lysine methyltransferase 2A (KMT2A) gene translocation?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
4. Does the patient have a susceptible nucleophosmin 1 (NPM1) mutation with no satisfactory alternative treatment options?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
5. The diagnosis IS NOT listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. **To facilitate approval, please list the diagnosis, guideline version, and page number:**	_____ **Sign and date below**	

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I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____
Prescriber Signature Date

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