Prior Authorization Request Form for
Rucaparib **(Rubraca)**

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

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 requested medication being prescribed by or in consultation with a hematologist/oncologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have a deleterious or suspected deleterious BRCA mutation as detected by an FDA-approved test?	☐ Yes Proceed to question **4**	☐ No Proceed to question **13**
4. Will the requested medication be used as either treatment or maintenance?	☐ Treatment Proceed to question **5**	☐ Maintenance Proceed to question **8**
5. Is the requested medication being prescribed for treatment of recurrent, high-grade, epithelial ovarian cancer (platinum-sensitive or platinum-resistant), fallopian tube or primary peritoneal cancer?	☐ Yes Proceed to question **6**	☐ No Proceed to question **13**
6. Has the patient received at least 2 prior lines of therapy?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Will the requested medication be used as a single agent?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**

Question		
8. Will the requested medication be used maintenance for one of the following?	☐ Relapsed platinum-sensitive, high-grade, advanced ovarian cancer, fallopian tube or primary peritoneal cancer – Proceed to **9** ☐ Newly diagnosed, advanced, high-grade, ovarian cancer, fallopian tube or primary peritoneal cancer – Proceed to **11** ☐ Other indication or diagnosis – Proceed to **13**	
9. Has the patient received 2 or more lines of platinum-based chemotherapy?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Was the patient objective in response (either complete or partial) to the most recent treatment regimen?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
11. Has the patient had a complete or partial response to primary therapy with a platinum-based therapy?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Will the requested medication be combined with bevacizumab (Avastin)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **15**
13. Please provide the diagnosis.	______________________________ Proceed to question **14**	
14. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **16**
16. Will the patient take highly effective contraception while taking the requested medication and for 6 months after the last dose?	☐ 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

[23 October 2019]

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