Prior Authorization Request Form for
Midostaurin (Rydapt)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Rydapt*	☐ Yes (subject to verification) Proceed to question **7**	☐ No Proceed to question **2**
2. For which indication is the requested medication being prescribed?	☐ Acute myelogenous leukemia (AML) – proceed to question **3** ☐ Advanced systemic mastocytosis (aggressive systemic mastocytosis; systemic mastocytosis associated with hematologic neoplasm) - Proceed to question **5** ☐ Mast cell leukemia - Proceed to question **5** ☐ Other – proceed to question **8**	
3. Is the AML positive for the FLT3 mutation, as determined by FDA-approved test?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Will Rydapt be used in combination with standard chemotherapy protocols?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is Rydapt being prescribed by or in consultation with a hematologist or oncologist?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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7. Is there documentation that the patient has experienced clinical and/or symptom improvement?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
8. Please provide the diagnosis.	_____ Proceed to question **9**	
9. 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

[31 July 2019]

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