Prior Authorization Request Form for
tazemetostat **(Tazverik)**

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 GREATER THAN or EQUAL to 16 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication prescribed by or in consultation with a hematologist/oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have pathologically confirmed metastatic or locally advanced epithelioid sarcoma not eligible for complete resection?	☐ 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. Will the patient be monitored for secondary malignancies (especially T-cell lymphoblastic lymphoma, myelodysplastic syndrome, and acute myeloid leukemia)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. What is the patient's gender?	☐ Male – Proceed to question **8** ☐ Female – Proceed to question **9**	

Prior Authorization Request Form for
tazemetostat **(Tazverik)**

8. Will the patient use effective contraception during treatment and for at least 3 months after the cessation of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
9. Is the patient of childbearing potential?	☐ Yes Proceed to question **10**	☐ No **Sign and date below**
10. Will the patient use effective contraception during treatment and for at least 6 months after the cessation of therapy?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Has it been confirmed that the patient is not pregnant by (-) HCG?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Will the patient breastfeed during treatment and for at least 1 week after the cessation of treatment?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge.

Please sign and date:

______________________________ Prescriber Signature

__________ Date

[05 August 2020]

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