Prior Authorization Request Form for
pexidartinib (**Turalio**)

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:**

1. Is the patient GREATER THAN or EQUAL TO 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by or in consultation with an oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have has symptomatic tenosynovial giant cell tumor associated with severe morbidity or functional limitations?	☐ Yes Proceed to question **4**	☐ No Proceed to question **5**
4. Is the tumor amenable to improvement with surgery?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **7**
5. Please provide the diagnosis?	_____ Proceed to question **6**	
6. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Will the patient be monitored for hepatotoxicity?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

Prior Authorization Request Form for
pexidartinib (**Turalio**)

8. Is the prescriber certified with the REMS program?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Is the patient enrolled in REMS program?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. What is the patient's age/gender?	☐ Male – proceed to question **13** ☐ Female of reproductive age – proceed to question **11** ☐ Female NOT of reproductive age – **Sign and date below**	
11. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Is the patient breast-feeding?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **13**
13. Will the patient take effective contraception during treatment and for 1 month after discontinuation in females, and 1 week after discontinuation in males with female partners?	☐ 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

[19 February 2020]

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