

TRICARE Prior Authorization Request Form for
vorasidenib (**Voranigo**)



JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

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

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior Authorization does not expire.

Step 1 Please complete patient and physician information (please print):

1 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 12 years of age or older?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the requested medication prescribed by or in consultation with an oncologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. What is the indication or diagnosis?	<input type="checkbox"/> Grade 2 astrocytoma or oligodendroglioma – Proceed to Question 4 <input type="checkbox"/> Other diagnosis – Proceed to Question 6	
4. Has the patient had surgery, including biopsy, sub-total resection, or gross total resection?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Does the patient have IDH1 or IDH2 mutations as demonstrated by an FDA-approved test?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

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6. 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

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date

[12 February 2025]

For Internal Use Only

<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: