Prior Authorization Request Form for
gilteritinib (Xospata)

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. Is the patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is this medication being prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Does the patient have relapsed or refractory acute myeloid leukemia?	☐ Yes Proceed to question **4**	☐ No Proceed to question **5**
4. Is there laboratory evidence to confirm Ferline McDonough Sarcoma (FMS)-like tyrosine kinase 3 (FLT3) mutation, as detected by an FDA-approved test?	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved
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. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **8**

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8. Will the patient be monitored for posterior reversible encephalopathy syndrome (PRES), prolonged QTc, and pancreatitis?	☐ 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

[29 May 2019]

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