TRICARE Prior Authorization Request Form for
niraparib (**Zejula**)

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 requested medication being prescribed by or in consultation with a hematologist/oncologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have a deleterious or suspected deleterious BRCA mutation as detected by an FDA-approved test?	☐ Yes Proceed to question **4**	☐ No Proceed to question **9**
4. Will Zejula be prescribed as a maintenance therapy for platinum-sensitive, relapsed, high-grade, ovarian cancers?	☐ Yes Proceed to question **5**	☐ No Proceed to question **8**
5. Has the patient received 2 or more lines of platinum-based chemotherapy?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Was the patient objective in response (either complete or partial) to the most recent treatment regimen?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Will the requested medication be combined with bevacizumab (Avastin)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **11**

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8. Will Zejula be prescribed as a first-line maintenance therapy in advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients who are in a complete or partial response to first-line platinum-based chemotherapy?	☐ Yes Proceed to question **11**	☐ No Proceed to question **9**
9. Please provide the diagnosis.	_____ Proceed to question **10**	
10. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. What is the patient's age/gender?	☐**Male** - proceed to question **15** ☐**Female of childbearing age** - proceed to question **12** ☐ **Female not of childbearing age - Sign and date below**	
12. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **13**
13. Will the patient take highly effective contraception while taking the requested medication and for 6 months after the last dose?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Will the patient breastfeed during treatment or within 1 month after the cessation of treatment?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
15. Is the patient aware that the requested medication may cause male infertility?	☐ 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

[30 December 2020]

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