TRICARE Prior Authorization Request Form for
idelalisib **(Zydelig)**

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 a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. For which indication is the requested medication being prescribed?	☐ **Relapsed/refractory therapy for CLL without del(17p)/TP53 mutation** - Proceed to question **4** ☐ **Relapsed/refractory therapy for CLL with del(17p)/TP53 mutation** - Proceed to question **7** ☐ **Relapsed/refractory marginal zone lymphoma after 2 prior therapies** - Proceed to question **7** ☐ **Other** - Proceed to question **5**	
4. Does the patient fit into any of the following categories? ○ Younger than 65 years of age ○ 65 years of age or older with significant comorbidities ○ Frail patient with significant comorbidities (not able to tolerate purine analogs)	☐ 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**

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7. Has the provider reviewed the REMS program included in the letter to healthcare providers and the fact sheet and has shared the medication guide and patient safety information card with the patient?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Will the patient be monitored for hepatotoxicity, colitis, intestinal perforation, pneumonitis, infection, neutropenia, and Steven Johnson Syndrome/toxic epidermal necrolysis?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Will the patient be monitored for cytomegalovirus reactivation?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Will the patient be provided prophylaxis for pneumocystis jiroveci pneumonia?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. What is the patient's age/gender?	☐ **Male not of reproductive potential** - **Sign and date below** ☐ **Male of reproductive potential** - Proceed to question **13** ☐ **Female not of reproductive potential** – **Sign and date below** ☐ **Female of reproductive potential -** Proceed to question **12**	
12. Will the female patients of reproductive potential use effective contraception during treatment and for at least 30 days after documentation?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
13. Will the male patients of reproductive potential use effective contraception during treatment and for at least 3 months after documentation?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
14. Is the patient pregnant or planning to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **15**
15. Will the patient breastfeed during 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

[28 September 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: