

Prior Authorization Request Form for avapritinib (Ayvakit)



JOHNS HOPKINS
MEDICINE

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**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?	<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 a hematologist/oncologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Does the patient have pathologically confirmed unresectable or metastatic gastrointestinal stromal tumor (GIST) harboring a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation with or without the D842V mutation?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No Proceed to question 4
4. Please provide the indication or diagnosis.	_____ Proceed to question 5	
5. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Will the provider monitor for intracranial bleeding and other central nervous system (CNS) adverse effects?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved

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7. What is the patient's gender?	<input type="checkbox"/> Male – Proceed to question 8 <input type="checkbox"/> Female – Proceed to question 9	
8. Will the patient use effective contraception during treatment and for at least 6 weeks after the cessation of therapy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
9. Is the patient of childbearing potential?	<input type="checkbox"/> Yes Proceed to question 10	<input type="checkbox"/> No Sign and date below
10. Will the patient use effective contraception during treatment and for at least 6 weeks after the cessation of therapy?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No STOP Coverage not approved
11. Is the patient pregnant?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 12
12. Has it been confirmed that the patient is not pregnant by (-) HCG?	<input type="checkbox"/> Yes Proceed to question 13	<input type="checkbox"/> No STOP Coverage not approved
13. Will the patient breastfeed during treatment and for at least 2 weeks after the cessation of treatment?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> 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

[05 August 2020]

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: