Prior Authorization Request Form for
enasidenib **(Idhifa) and** ivosidenib **(Tibsovo)**

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 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 hematologist or oncologist?	☐ Yes **Proceed to question 3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have a diagnosis of relapsed or refractory acute myelogenous leukemia (AML)?	☐ Yes **Proceed to question 4**	☐ No **Proceed to question 10**
4. For which medication is coverage being requested?	☐ Idhifa **Proceed to question 5**	☐ Tibsovo **Proceed to question 9**
5. Does the patient exhibit the IDH2 mutation as determined by an FDA approved test?	☐ Yes **Proceed to question 6**	☐ No **STOP** **Coverage not approved**
6. Is this request for continuation of therapy?	☐ Yes **Proceed to question 7**	☐ No **Proceed to question 8**
7. Has the patient experienced disease progression?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date on next page**

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8. Will the requested medication be used in combination with standard chemotherapy protocols?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
9. Does the patient exhibit the IDH1 mutation as determined by an FDA approved test?	☐ Yes **Proceed to question 11**	☐ No **STOP** **Coverage not approved**
10. Has the patient been newly diagnosed with acute myelogenous leukemia (AML) and is 75 years and older, or has comorbidities that preclude use of intensive induction chemotherapy?	☐ Yes **Proceed to question 11**	☐ No **Proceed to question 13**
11. Will the patient be monitored for differentiation syndrome?	☐ Yes **Proceed to question 12**	☐ No **STOP** **Coverage not approved**
12. Will the patient be monitored for Guillain-Barre Syndrome?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
13. Please provide the diagnosis.	_____ Proceed to question **14**	
14. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B	☐ 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

[4 December 2019]

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