Prior Authorization Request Form for
olaparib **(Lynparza)**

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 **15**
4. Will the requested medication be used as either treatment or maintenance?	☐ Treatment Proceed to question **5**	☐ Maintenance Proceed to question **10**
5. Will the requested medication be used as treatment for one or more of the following diagnoses?	☐ Recurrent or Stage IV Triple negative breast cancer - Proceed to **17** ☐ Recurrent or Stage IV hormone receptor positive (ER, PR, or both) HER2 negative breast cancer – Proceed to **6** ☐ Recurrent advanced ovarian cancers (platinum-sensitive or platinum-resistant), fallopian tube or primary peritoneal cancers – Proceed to **8** ☐ Other indication or diagnosis – Proceed to **15**	
6. Has the patient been previously treated with prior endocrine therapy?	☐ Yes Proceed to question **17**	☐ No Proceed to question **7**
7. Is the patient an appropriate candidate for endocrine therapy?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**

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8. Has the patient received at least 3 prior lines of therapy?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Will the requested medication be used as a single agent?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**
10. Will the patient use the requested medication as a maintenance therapy for one of the following diagnoses?	☐ Platinum-sensitive, relapsed, epithelial ovarian cancer, fallopian tube or primary peritoneal cancer- Proceed to **11** ☐ Newly diagnosed, advanced, high-grade, epithelial ovarian cancer, fallopian tube or primary peritoneal cancer– Proceed to **13** ☐ Other indication or diagnosis – Proceed to **15**	
11. Has the patient received 2 or more lines of platinum-based chemotherapy?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Was the patient objective in response (either complete or partial) to the most recent treatment regimen?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
13. Has the patient had a complete or partial response to primary therapy with a platinum-based therapy?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Will the requested medication be combined with bevacizumab (Avastin)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **17**
15. Please provide the diagnosis.	_____ Proceed to question **16**	
16. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **18**
18. Will the patient take highly effective contraception while taking the requested medication and for 6 months after the last dose?	☐ 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

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