

Prior Authorization Request Form for pemigatinib (Pemazyre)



JOHNS HOPKINS
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**FAX Completed Form and
Applicable Progress Notes to:
(410) 424-4037**

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):

<p>1 Patient Name: _____</p> <p>Address: _____</p> <p>Sponsor ID # _____</p> <p>Date of Birth: _____</p>	<p>Physician Name: _____</p> <p>Address: _____</p> <p>Phone #: _____</p> <p>Secure Fax #: _____</p>
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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 or oncologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Does the patient have a diagnosis of pathologically confirmed unresectable or advanced/metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Proceed to question 5
4. Has the diagnosis been detected by an FDA-approved test?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
5. Please provide the indication or 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?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved

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7. Will the patient be monitored for ophthalmologic disorders including pre-treatment screening for retinal disorders?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved
8. Will the patient be monitored for hyperphosphatemia?	<input type="checkbox"/> Yes Proceed to question 9	<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. What is the patient's gender?	<input type="checkbox"/> Male – Proceed to question 11 <input type="checkbox"/> Female – Proceed to question 12	
11. Will the patient use effective contraception during treatment and for at least 1 week after the cessation of therapy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
12. Will the patient use effective contraception during treatment and for at least 1 week after the cessation of therapy?	<input type="checkbox"/> Yes Proceed to question 13	<input type="checkbox"/> No STOP Coverage not approved
13. Is the patient pregnant?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 14
14. Has it been confirmed that the patient is not pregnant by (-) HCG?	<input type="checkbox"/> Yes Proceed to question 15	<input type="checkbox"/> No STOP Coverage not approved
15. Will the patient not breastfeed during treatment and for at least 1 week after the cessation of treatment?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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

[11 November 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: