

Prior Authorization Request Form for
talazoparib (Talzenna)



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?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the requested medication being prescribed by or 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 deleterious or suspected deleterious germline BRCA-mutated (gBRCAm) breast cancer?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Proceed to question 5
4. Does the patient have human epidermal growth factor receptor 2-negative (HER2-) breast cancer?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

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Step I certify the above is true to the best of my knowledge. Please sign and date:

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Prescriber Signature

Date

[29 May 2019]

For Internal Use Only

Approved:

Duration of Approval: ____month(s)

Denied:

Authorized By:

Incomplete/Other:

PA#:

Date Faxed to MD:

Date Decision Rendered: