

Prior Authorization Request Form for
niraparib (**Zejula**)



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?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Does the patient have a deleterious or suspected deleterious BRCA mutation as detected by an FDA-approved test?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Proceed to question 8
4. Will Niraparib be prescribed as a maintenance therapy for platinum-sensitive, relapsed, high-grade, ovarian cancers?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Proceed to question 8
5. Has the patient received 2 or more lines of platinum-based chemotherapy?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Was the patient objective in response (either complete or partial) to the most recent treatment regimen?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
7. Will the requested medication be combined with bevacizumab (Avastin)?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 10

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8. Please provide the diagnosis.	_____ Proceed to question 9	
9. 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 10	<input type="checkbox"/> No STOP Coverage not approved
10. Is the patient pregnant or actively trying to become pregnant?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 11
11. Will the patient take highly effective contraception while taking Zejula and for 6 months after the last dose?	<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

[23 October 2019]

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: