US Family Health Plan

Prior Authorization Request Form for

# Olaparib (Lynparza)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
**Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**

QUESTIONS? **Call 1-877-880-7007**

## 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:**

| | | |
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| **1. Is the requested medication being prescribed by or in consultation with a hematologist/oncologist or urologist?** | ☐ Yes<br>Proceed to question **2** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **2. Is the patient 18 years of age or older?** | ☐ Yes<br>Proceed to question **3** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **3. Is the requested medication being used as treatment or maintenance therapy?** | ☐ Treatment<br>Proceed to question **4** | ☐ Maintenance<br>Proceed to question **12** |
| **4. 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 **11**<br>☐ Recurrent or Stage IV hormone receptor positive (ER, PR, or both) HER2 negative breast cancer – Proceed to **5**<br>☐ Recurrent advanced ovarian cancers (platinum-sensitive or platinum resistant), fallopian tube or primary peritoneal cancers – Proceed to **9**<br>☐ Deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene (for example, BRCA, ATM)-mutated metastatic castration-resistant prostate cancer (mCRPC) – proceed to **7**<br>☐ Deleterious or suspected deleterious gBRCam, (HER2)-negative, high-risk early breast cancer – Proceed to **8**<br>☐ Deleterious or suspected deleterious BRCA-mutated (BRCAm) metastatic castration-resistant prostate cancer (mCRPC) – Proceed to **18**<br>☐ Other indication or diagnosis – Proceed to **24** | |

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| **5. Has the patient been previously treated with prior endocrine therapy?** | ☐ Yes<br>Proceed to question **11** | ☐ No<br>Proceed to question **6** |
| **6. Is the patient an inappropriate candidate for endocrine therapy?** | ☐ Yes<br>Proceed to question **11** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **7. Has the patient progressed following prior androgen receptor-directed therapy (for example, abiraterone or enzalutamide)?** | ☐ Yes<br>Proceed to question **19** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **8. Has the patient been treated with neoadjuvant or adjuvant chemotherapy?** | ☐ Yes<br>Proceed to question **11** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **9. Has the patient received at least 3 prior lines of therapy?** | ☐ Yes<br>Proceed to question **10** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **10. Will the requested medication be used as a single agent?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>Proceed to question **11** |
| **11. Does the patient have a deleterious or suspected deleterious BRCA mutation as detected by an FDA-approved test?** | ☐ Yes<br>Proceed to question **19** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **12. 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 **13**<br>☐ Newly diagnosed, advanced, high-grade, epithelial ovarian cancer, fallopian tube or primary peritoneal cancer– Proceed to **15**<br>☐ Metastatic pancreatic adenocarcinoma – Proceed to **16**<br>☐ Other indication or diagnosis – Proceed to **24** | |
| **13. Has the patient received 2 or more lines of platinum-based chemotherapy?** | ☐ Yes<br>Proceed to question **14** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **14. Was the patient objective in response (either complete or partial) to the most recent treatment regimen?** | ☐ Yes<br>Proceed to question **17** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **15. Has the patient had a complete or partial response to primary therapy with a platinum-based therapy?** | ☐ Yes<br>Proceed to question **19** | ☐ No<br>**STOP**<br>**Coverage not approved** |

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| **16. Has the disease progressed on at least 16 weeks of a first-line platinum-based chemotherapy regimen?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>Proceed to question **19** |
| **17. Will the requested medication be combined with bevacizumab (Avastin)?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>Proceed to question **19** |
| **18. Will the requested medication be used in combination with abiraterone AND prednisone OR prednisolone?** | ☐ Yes<br>Proceed to question **19** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **19. What is the patient's age/gender?** | ☐ **Male** - proceed to question **23**<br>☐ **Female of childbearing age** - proceed to question **20**<br>☐ **Female not of childbearing age** - Sign and date below | |
| **20. Will the patient take highly effective contraception while taking the requested medication and for 6 months after the last dose?** | ☐ Yes<br>Proceed to question **21** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **21. Is the patient pregnant or actively trying to become pregnant?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>Proceed to question **22** |
| **22. Will the patient avoid breastfeeding during treatment or within one month after the cessation of therapy?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **23. Will the patient use effective contraception while taking the requested medication and for at least 3 months after cessation of therapy?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **24. Please provide the diagnosis.** | _____<br>**Proceed to question 25** | |
| **25. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?** | ☐ Yes<br>Proceed to question **26** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **26. What is the patient's age/gender?** | ☐ **Male** - proceed to question **30**<br>☐ **Female of childbearing age** - proceed to question **27**<br>☐ **Female not of childbearing age - Sign and date below** | |
| **27. Will the patient take highly effective contraception while taking the requested medication and for 6 months after the last dose?** | ☐ Yes<br>Proceed to question **28** | ☐ No<br>**STOP**<br>**Coverage not approved** |

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| **28. Is the patient pregnant or actively trying to become pregnant?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>Proceed to question **29** |
| **29. Will the patient avoid breastfeeding during treatment or within one month after the cessation of therapy?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **30. Will the patient use effective contraception while taking the requested medication and for at least 3 months after cessation of therapy?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |

**Step 3**

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

_____ _____

Prescriber Signature Date