

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:

1. Is the requested medication being prescribed by or in consultation with a hematologist/oncologist or urologist?	<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. Is the requested medication being used as treatment or maintenance therapy?	<input type="checkbox"/> Treatment Proceed to question 4	<input type="checkbox"/> Maintenance Proceed to question 11
4. Will the requested medication be used as treatment for one or more of the following diagnoses?	<input type="checkbox"/> Recurrent or Stage IV Triple negative breast cancer - Proceed to 10 <input type="checkbox"/> Recurrent or Stage IV hormone receptor positive (ER, PR, or both) HER2 negative breast cancer – Proceed to 5 <input type="checkbox"/> Recurrent advanced ovarian cancers (platinum-sensitive or platinum-resistant), fallopian tube or primary peritoneal cancers – Proceed to 7 <input type="checkbox"/> 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 9 <input type="checkbox"/> Other indication or diagnosis – Proceed to 17	
5. Has the patient been previously treated with prior endocrine therapy?	<input type="checkbox"/> Yes Proceed to question 10	<input type="checkbox"/> No Proceed to question 6

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<p>6. Is the patient an inappropriate candidate for endocrine therapy?</p>	<p><input type="checkbox"/> Yes Proceed to question 10</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>7. Has the patient received at least 3 prior lines of therapy?</p>	<p><input type="checkbox"/> Yes Proceed to question 8</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>8. Will the requested medication be used as a single agent?</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 10</p>
<p>9. Has the patient progressed following prior androgen receptor-directed therapy and taxane-based chemotherapy?</p>	<p><input type="checkbox"/> Yes Proceed to question 19</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>10. Does the patient have a deleterious or suspected deleterious BRCA mutation as detected by an FDA-approved test?</p>	<p><input type="checkbox"/> Yes Proceed to question 19</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>11. Will the patient use the requested medication as a maintenance therapy for one of the following diagnoses?</p>	<p><input type="checkbox"/> Platinum-sensitive, relapsed, epithelial ovarian cancer, fallopian tube or primary peritoneal cancer- Proceed to 12</p> <p><input type="checkbox"/> Newly diagnosed, advanced, high-grade, epithelial ovarian cancer, fallopian tube or primary peritoneal cancer– Proceed to 14</p> <p><input type="checkbox"/> Metastatic pancreatic adenocarcinoma – Proceed to 15</p> <p><input type="checkbox"/> Other indication or diagnosis – Proceed to 17</p>	
<p>12. Has the patient received 2 or more lines of platinum-based chemotherapy?</p>	<p><input type="checkbox"/> Yes Proceed to question 13</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>13. Was the patient objective in response (either complete or partial) to the most recent treatment regimen?</p>	<p><input type="checkbox"/> Yes Proceed to question 16</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>14. Has the patient had a complete or partial response to primary therapy with a platinum-based therapy?</p>	<p><input type="checkbox"/> Yes Proceed to question 19</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>15. Has the disease progressed on at least 16 weeks of a first-line platinum-based chemotherapy regimen?</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 19</p>
<p>16. Will the requested medication be combined with bevacizumab (Avastin)?</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 19</p>

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17. Please provide the diagnosis.	<hr style="width: 80%; margin: 0 auto;"/> Proceed to question 18	
18. 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 19	<input type="checkbox"/> No STOP Coverage not approved
19. What is the patient's age/gender?	<input type="checkbox"/> Male - proceed to question 23 <input type="checkbox"/> Female of childbearing age - proceed to question 20 <input type="checkbox"/> Female not of childbearing age - Sign and date below	
20. 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 21
21. Will the patient take highly effective contraception while taking the requested medication and for 6 months after the last dose?	<input type="checkbox"/> Yes Proceed to question 22	<input type="checkbox"/> No STOP Coverage not approved
22. Will the patient breastfeed during treatment or within one month after the cessation of treatment?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Sign and date below
23. Will the patient use effective contraception while taking the requested medication and for at least 3 months after cessation of therapy?	<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