US Family Health Plan
Prior Authorization Request Form for decitabine/ cedazuridine (**Inqovi**)

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 patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication prescribed by or in consultation with a hematologist/oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. For which indication or diagnosis is the requested medication being prescribed?	☐ Myelodysplastic syndromes (MDS) - Proceed to question **4** ☐ Other - Proceed to question **5**	
4. Does the patient have the following French-American-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, and chronic myelomonocytic leukemia [CMML]) and intermediate-1, intermediate-2, and high-risk International Prognostic Scoring System groups?	☐ Yes Proceed to question **7**	☐ 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?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. Will the provider agree to monitor for myelosuppression/cytopenias?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient of childbearing potential?	☐ Yes Proceed to question **9**	☐ No **Sign and date below**
9. What is the patient's gender?	☐ Male – Proceed to question **10** ☐ Female – Proceed to question **11**	
10. Will the patient use effective contraception during treatment and for at least 3 months after the cessation of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
11. Will the patient use effective contraception during treatment and for at least 6 months after the cessation of therapy?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **13**
13. Has it been confirmed that the patient is not pregnant by (-) HCG?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Will the patient not breastfeed during treatment and for at least 2 weeks after the cessation of treatment?	☐ Yes **Sign and date below**	☐ 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 _____

[10 February 2021]