

USFHP 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

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Prior authorization does not expire. Clinical documentation may be required.

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?	☐ Yes Proceed to question 2	☐ No STOP Coverage not approved
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question 3	☐ No STOP Coverage not approved
3. Is the requested medication being used as treatment or maintenance therapy?	☐ Treatment Proceed to question 4	☐ Maintenance 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 ☐ Recurrent or Stage IV hormone receptor positive (ER, PR, or both) HER2 negative breast cancer – Proceed to 5 ☐ Recurrent advanced ovarian cancers (platinum-sensitive or platinum resistant), fallopian tube or primary peritoneal cancers – Proceed to 9 ☐ 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 ☐ Deleterious or suspected deleterious gBRCAm, (HER2)-negative, high-risk early breast cancer – Proceed to 8 ☐ Deleterious or suspected deleterious BRCA-mutated (BRCAm) metastatic castration-resistant prostate cancer (mCRPC) – Proceed to 18 ☐ Other indication or diagnosis – Proceed to 19	

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

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15. Has the patient had a complete or partial response to primary therapy with a platinum-based therapy?	☐ Yes Sign and date below	☐ No STOP Coverage not approved
16. Has the disease progressed on at least 16 weeks of a first-line platinum-based chemotherapy regimen?	☐ Yes STOP Coverage not approved	☐ No Sign and date below
17. Will the requested medication be combined with bevacizumab (Avastin)?	☐ Yes STOP Coverage not approved	☐ No Sign and date below
18. Will the requested medication be used in combination with abiraterone AND prednisone OR prednisolone?	☐ Yes Sign and date below	☐ No STOP Coverage not approved
19. The diagnosis IS NOT listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. If so, please list the diagnosis: To facilitate approval, please list the diagnosis, guideline version and provide page number.	_____ Sign and date below	

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

3

Prescriber Signature

Date

[2 April 2025]