US Family Health Plan
Prior Authorization Request Form for
ixazomib **(Ninlaro)**

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:**

Question	Yes	No
1. **Is the patient GREATER THAN or EQUAL to 18 years of age?**	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. **Is the requested medication being prescribed by or consultation with a hematologist or oncologist?**	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. **Does the patient have a diagnosis of multiple myeloma?**	☐ Yes Proceed to question **4**	☐ No Proceed to question **13**
4. **Has the patient received hematopoietic cell transplant (HCT)?**	☐ Yes Proceed to question **5**	☐ No Proceed to question **6**
5. **Will the patient receive Ninlaro as maintenance therapy following primary therapy and HCT?**	☐ Yes Proceed to question **12**	☐ No **STOP** Coverage not approved
6. **Has the patient had disease progression while on a bortezomib (Velcade) or a carfilzomib (Kyprolis) - containing regimen?**	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **7**
7. **Has the patient had adverse drug reactions/ adverse drug event/ allergy or is not a candidate for bortezomib AND carfilzomib?**	☐ Yes Proceed to question **8**	☐ No Proceed to question **10**

Question	Yes	No
8. Has the patient had adverse drug reactions/ adverse drug event/ allergy or is not a candidate for carfilzomib and has high risk cytogenetics?	☐ Yes Proceed to question **10**	☐ No Proceed to question **9**
9. Will the patient be starting Ninlaro as the third (or higher) line of therapy?	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
10. Will the requested medication be used in combination with lenalidomide (Revlimid), pomalidomide (Pomalyst), OR thalidomide (Thalomid)?	☐ Yes Proceed to question **11**	☐ No **STOP** Coverage not approved
11. Will the requested medication be used in combination with dexamethasone?	☐ Yes Proceed to question **12**	☐ No **STOP** Coverage not approved
12. Will the patient be using the requested medication concurrently with bortezomib or carfilzomib?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**
13. Please provide the diagnosis.	______________________________ Proceed to question **14**	
14. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ 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

[09 June 2021]