US Family Health Plan

Prior Authorization Request Form for

Enasidenib (Idhifa) and Ivosidenib (Tibsovo)

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**

Prior authorization for Idhifa will expire in 1 year. Prior authorization for Tibsovo is indefinite.

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 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 in consultation with hematologist or oncologist?	☐ Yes **Proceed to question 3**	☐ No **STOP** **Coverage not approved**
3. For which medication is coverage being requested?	☐ Idhifa **Proceed to question 4**	☐ Tibsovo **Proceed to question 11**
4. Does the patient have a diagnosis of relapsed or refractory acute myelogenous leukemia (AML)?	☐ Yes **Proceed to question 5**	☐ No **Proceed to question 9**
5. Does the patient exhibit the IDH2 mutation as determined by an FDA approved test?	☐ Yes **Proceed to question 6**	☐ No **Proceed to question 9**
6. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Idhifa.*	☐ Yes **Proceed to question 7**	☐ No **Proceed to question 8**
7. Has the patient experienced disease progression?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date on next page**

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8. Will the requested medication be used in combination with standard chemotherapy protocols?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
9. Please provide the diagnosis.	_____ Proceed to question **10** **Please provide the diagnosis.**	
10. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B	☐ Yes **Sign and date below**	☐ No **STOP coverage not approved**
11. Does the patient have a diagnosis of relapsed/refractory acute myeloid leukemia (AML) with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation as detected by a FDA-approved test?	☐ Yes **Proceed to question 19**	☐ No **Proceed to question 12**
12. Has the patient been newly diagnosed with acute myelogenous leukemia (AML)?	☐ Yes **Proceed to question 13**	☐ No **Proceed to question 16**
13. Is the patient using Tibsovo as monotherapy OR in combination with azacitidine (Vidaza)?	☐ Yes **Proceed to question 14**	☐ No **Proceed to question 16**
14. Is the patient GREATER THAN or EQUAL TO 75 years of age?	☐ Yes **Proceed to question 19**	☐ No **Proceed to question 15**
15. Does the patient have comorbidities that preclude use of intensive induction chemotherapy with a susceptible IDH1 mutation as detected by a FDA-approved test?	☐ Yes **Proceed to question 19**	☐ No **Proceed to question 16**
16. Does the patient have previously treated, locally advanced, or metastatic cholangiocarcinoma with an IDH1 mutation as detected by a FDA-approved test?	☐ Yes **Proceed to question 19**	☐ No **Proceed to question 17**
17. Please provide the diagnosis.	_____ Proceed to question **18**	
18. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B	☐ Yes **Proceed to question 19**	☐ No **STOP** **Coverage not approved**
19. Will the patient be monitored for differentiation syndrome?	☐ Yes **Proceed to question 20**	☐ No **STOP** **Coverage not approved**

	20. Will the patient be monitored for Guillain-Barre Syndrome?	☐ 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 _____