US Family Health Plan
Prior Authorization Request Form for
niraparib (**Zejula**)

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 requested medication being prescribed by or in consultation with a hematologist/oncologist?	☐ 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. Does the patient have a deleterious or suspected deleterious BRCA mutation as detected by an FDA-approved test?	☐ Yes Proceed to question **4**	☐ No Proceed to question **9**
4. Will Zejula be prescribed as a maintenance therapy for platinum-sensitive, relapsed, high-grade, ovarian cancers?	☐ Yes Proceed to question **5**	☐ No Proceed to question **8**
5. Has the patient received 2 or more lines of platinum-based chemotherapy?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Was the patient objective in response (either complete or partial) to the most recent treatment regimen?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Will the requested medication be combined with bevacizumab (Avastin)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **11**

8. **Will Zejula be prescribed as a first-line maintenance therapy in advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients who are in a complete or partial response to first-line platinum-based chemotherapy?**	☐ Yes Proceed to question **11**	☐ No Proceed to question **9**
9. **Please provide the diagnosis.**	______________________ Proceed to question **10**	
10. **Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?**	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. **What is the patient's age/gender?**	☐ **Male** - proceed to question **15** ☐ **Female of childbearing age** - proceed to question **12** ☐ **Female not of childbearing age - Sign and date below**	
12. **Is the patient pregnant or actively trying to become pregnant?**	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **13**
13. **Will the patient take highly effective contraception while taking the requested medication and for 6 months after the last dose?**	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. **Will the patient breastfeed during treatment or within 1 month after the cessation of treatment?**	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
15. **Is the patient aware that the requested medication may cause male infertility?**	☐ 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