TRICARE Prior Authorization Request Form for
ropeginterferon alfa-2b-njft injection **(Besremi)**

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Initial and renewal prior authorization expires after 1 year. For renewal of therapy an initial Tricare prior authorization approval is 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:**

Question		
1. Provider acknowledges that another pegylated interferon (Pegasys) is available at the formulary copay and without requiring prior authorization.	☐ Acknowledged Proceed to question **2**	
2. 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 Besremi.*	☐ Yes (subject to verification) Proceed to question **3**	☐ No Proceed to question **4**
3. Does the patient have a documented improvement in symptoms?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
4. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the requested medication prescribed by or in consultation with a hematologist/oncologist?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. What is the indication or diagnosis? Note: Non-FDA approved uses are NOT approved including myeloproliferative neoplasms, essential thrombocythemia (ET), or adult T-cell leukemia (ATL).	☐ Polycythemia vera (PV) - Proceed to question **7** ☐ Other - Proceed to question **10**	

TRICARE Prior Authorization Request Form for
ropeginterferon alfa-2b-njft injection **(Besremi)**

Question		
7. Is the patient currently taking aspirin 81-100mg daily and is undergoing regular phlebotomy (to maintain hematocrit less than 45%) unless relatively contraindicated?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have low-risk PV?	☐ Yes Proceed to question **9**	☐ No Proceed to question **12**
9. Is the patient symptomatic with potential indications for cytoreductive therapy (new thrombosis or disease-related major bleeding; frequent phlebotomy or intolerant of phlebotomy; splenomegaly; progressive thrombocytosis and/or leukocytosis; disease-related symptoms (for example, pruritus, night sweats fatigue)?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
10. Please provide the diagnosis.	______________________________ Proceed to question **11**	
11. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **12**	☐ No **STOP** Coverage not approved
12. What is the patient's gender?	☐ Male **Sign and date below**	☐ Female Proceed to question **13**
13. Is the patient of childbearing potential?	☐ Yes Proceed to question **14**	☐ No **Sign and date below**
14. Does the patient agree to use effective contraception during treatment and for at least 8 weeks after the cessation of therapy?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Has it been confirmed that the patient is not pregnant by negative hCG (human chorionic gonadotropin)?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Will the patient avoid breastfeeding during treatment and for at least 8 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

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: