TRICARE Prior Authorization Request Form for
eflornithine tablets (Iwilfin)

JOHNS HOPKINS
HEALTH PLANS

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

USFHP Pharmacy Prior Authorization Form

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.

Prior authorization does not expire.

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 an oncologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have high-risk neuroblastoma?	☐ Yes Proceed to question **5**	☐ No Proceed to question **3**
3. What is the diagnosis or indication?	_____ Proceed to question **4**	
4. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the requested medication being used to reduce the risk of relapse?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Has the patient had at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. Is the provider aware of all warnings, screening, and monitoring precautions for the requested medication?	☐ 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 _____

[14 August 2024]

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