TRICARE Prior Authorization Request Form for
daprodustat **(Jesduvroq)**

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

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.

Initial approval expires after 6 months, renewal approves for lifetime. For renewal of therapy an initial Tricare prior authorization approval is required. After six months, PA must be resubmitted.

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. 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 Jesduvroq.*	☐ Yes (subject to verification) Proceed to question **9**	☐ No Proceed to question **2**
2. The provider acknowledges that epoetin alfa-epbx (Retacrit) is the preferred erythropoietin stimulating agent (ESA) for TRICARE and is available without prior authorization.	☐ Acknowledged Proceed to question **3**	
3. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication prescribed by or in consultation with a nephrologist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. What is the indication or diagnosis?	☐ Anemia due to chronic kidney disease - Proceed to question **6** ☐ No – **STOP Coverage not approved**	
6. Has the patient experienced an inadequate response or adverse reaction to Retacrit?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Has the patient been receiving dialysis for at least 4 months?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the provider aware of the warnings, screening, and monitoring precautions for the requested medication?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
9. Has the patient had a positive response to therapy as shown by an increase or stabilization in hemoglobin levels or a reduction or absence in red blood cell transfusions?	☐ 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

[8 May 2024]

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