TRICARE Prior Authorization Request Form for
momelotinib **(Ojjaara)**

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.

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 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 consultation with a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the diagnosis or indication?	☐ Intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis with anemia – proceed to question **6** ☐ Other – proceed to question **4**	
4. Please provide the diagnosis.	_____ Proceed to question **5**	
5. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the provider aware of the warnings, screening, and monitoring precautions for the requested medication?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. What is the patient's gender?	☐ Male **Sign and date below**	☐ Female Proceed to question **8**
8. Is the patient of reproductive potential?	☐ Yes Proceed to question **9**	☐ No **Sign and date below**
9. Will the patient use effective contraception during treatment and for 1 week after the last dose?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has it been confirmed that the patient is not pregnant or is not planning to become pregnant?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the patient avoid breastfeeding during treatment and for at least 1 week after discontinuation?	☐ 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: