Prescriber Criteria Form Zejula 2024 PA Fax 1689-A v2 010124.docx Zejula (niraparib) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Zejula (niraparib).

Drug Name: Zejula (niraparib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for maintenance treatment of advanced (e.g., stage II-IV) epithelial ovarian, fallopian tube, or primary peritoneal cancer? [If yes, then skip to question 4.]	Yes	No
2	Is the requested drug being prescribed for maintenance treatment of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer? [If no, then skip to question 5.]	Yes	No
3	Does the patient have a deleterious or suspected deleterious germline breast cancer gene (BRCA) mutation? [If no, then no further questions.]	Yes	No
4	Is the request for a patient who is in complete or partial response to platinum-based chemotherapy? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of uterine leiomyosarcoma? [If no, then no further questions.]	Yes	No
6	Is the requested drug being used as second line-therapy? [If no, then no further questions.]	Yes	No
7	Does the patient have BRCA (breast cancer susceptibility gene) -altered disease?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____