US Family Health Plan
Prior Authorization Request Form for
duvelisib (**Copiktra**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

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 a hematologist/oncologist?	☐ Yes proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient greater than or equal to 18 years of age?	☐ Yes proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. For which indication is the requested medication being prescribed?	☐ relapsed or refractory chronic lymphocytic leukemia (CLL) - proceed to question **4** ☐ relapsed or refractory small lymphocytic lymphoma (SLL) - proceed to question **4** ☐ relapsed or refractory follicular lymphoma (FL) - proceed to question **4** ☐ marginal zone lymphoma (MZL) - proceed to question **5** ☐ Other: proceed to question **6**	
4. Has the patient undergone at least two prior systemic therapies?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the diagnosis been pathologically confirmed?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**

6. Please provide the diagnosis.	_____ Proceed to question **7**	
7. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the provider aware and has informed patient of the risk of serious, life-threatening, and fatal infections, including Pneumocystis jiroveci pneumonia (PJP) and cytomegalovirus (CMV); diarrhea; colitis; cutaneous reactions, including drug rash with eosinophilia and systemic symptoms (DRESS) and Stevens Johnson Syndrome spectrum reactions, including Toxic Epidermal Necrolysis; pneumonitis; hepatotoxicity; and neutropenia?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have evidence of active infection, diarrhea, colitis, serious cutaneous disease, pneumonitis, hepatitis, significantly elevated liver-associated enzymes, or neutropenia?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **10**
10. What is the patient's age/gender?	☐ **Male** - proceed to question **14** ☐ **Female of childbearing age** - proceed to question **11** ☐ **Female not of childbearing age** - proceed to question **16**	
11. Has it been confirmed that the patient is not pregnant by a negative HCG test?	☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Does the patient agree to use contraception during treatment and for at least 1 month after the cessation of treatment?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Does the patient agree to not breastfeed during treatment and for at least 1 month after the cessation of treatment?	☐ Yes proceed to question **16**	☐ No **STOP** **Coverage not approved**

14. Do male patients with female partners agree to use contraception during treatment and for at least 1 month after the cessation of treatment?	☐ Yes proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Are patients informed that Copiktra may cause male infertility?	☐ Yes proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Is the prescriber enrolled in Copiktra REMS program?	☐ 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