US Family Health Plan
Prior Authorization Request Form for
pexidartinib (**Turalio**)

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 **617-562-5296**

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:

Question		
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 in consultation with an oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have has symptomatic tenosynovial giant cell tumor associated with severe morbidity or functional limitations?	☐ Yes Proceed to question **4**	☐ No Proceed to question **5**
4. Is the tumor amenable to improvement with surgery?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **7**
5. Please provide the diagnosis?	____________________ Proceed to question **6**	
6. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Will the patient be monitored for hepatotoxicity?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

Question		
8. Is the prescriber certified with the REMS program?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Is the patient enrolled in REMS program?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. What is the patient's age/gender?	☐ Male – proceed to question **13** ☐ Female of reproductive age – proceed to question **11** ☐ Female NOT of reproductive age – **Sign and date below**	
11. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Is the patient breast-feeding?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **13**
13. Will the patient take effective contraception during treatment and for 1 month after discontinuation in females, and 1 week after discontinuation in males with female partners?	☐ 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

[19 February 2020]