US Family Health Plan
Prior Authorization Request Form for
Larotrectinib (**Vitrakvi**) capsules and oral solution

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 this medication being prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. For which indication is the requested medication being prescribed?	☐ Solid tumor – proceed to question **3** ☐ Advanced metastatic non-small cell lung cancer (NSCLC) – proceed to question **5** ☐ Other – proceed to question **6**	
3. Is the solid tumor metastatic or would surgical resection result in severe morbidity?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Has the solid tumor progressed despite alternative treatment or there are no satisfactory alternative treatments?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Does the tumor have neurotropic tropomysin receptor kinase (NTRK) gene fusion without a known acquired resistance mutation?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved
6. Please provide the diagnosis.	_____ Proceed to question **7**	

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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 patient of reproductive age?	☐ Yes Proceed to question **9**	☐ No Proceed to question **10**
9. Will the patients (males and females) of reproductive potential use effective contraception during treatment and for at least 1 week after discontinuation?	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
10. Is the patient a female?	☐ Yes Proceed to question **11**	☐ No Proceed to question **12**
11. Has it been confirmed that the patient will not breastfeed during treatment and for 1 week after cessation of treatment?	☐ Yes Proceed to question **12**	☐ No **STOP** Coverage not approved
12. Which formulation is being requested?	☐ **Capsules** - **Sign and date below** ☐ **Oral solution** - Proceed to question **13**	
13. Does the patient have difficulty swallowing the capsules?	☐ 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

[08 April 2020]