US Family Health Plan

Prior Authorization Request Form for

Brigatinib (Alunbrig), Alectinib (Alecensa), and Ceritinib (Zykadia)

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**

Clinical documentation may be required for approval.

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 or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Does the patient have a documented diagnosis of metastatic non-small cell lung cancer (NSCLC)?	☐ Yes Proceed to question **3**	☐ No Proceed to question **4**
3. Is the NSCLC anaplastic lymphoma kinase (ALK) positive as detected by an FDA-approved test?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
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 **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

[29 January 2020]