US Family Health Plan
Prior Authorization Request Form for
Avapritinib (Ayvakit)

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**

Prior authorization does not expire.

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	Yes	No
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 prescribed by or in consultation with a hematologist/oncologist?**	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. **Does the patient have pathologically confirmed unresectable or metastatic gastrointestinal stromal tumor (GIST) harboring a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation with or without the D842V mutation?**	☐ Yes Proceed to question **8**	☐ No Proceed to question **4**
4. **Does the patient have advanced systemic mastocytosis (includes patients with aggressive systemic mastocytosis, systemic mastocytosis with an associated hematologic neoplasm, and mast cell leukemia)?**	☐ Yes Proceed to question **8**	☐ No Proceed to question **5**
5. **Does the patient have indolent systemic mastocytosis (ISM) with a platelet count GREATER THAN OR EQUAL TO 50 x 10^9/L?**	☐ Yes Proceed to question **8**	☐ No Proceed to question **6**
6. **Please provide the indication or diagnosis.**	______________________ Proceed to question **7**	

Question	Yes	No
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. Will the provider monitor for intracranial bleeding and other central nervous system (CNS) adverse effects?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. What is the patient's gender?	☐ Male – Proceed to question **10** ☐ Female – Proceed to question **11**	
10. Will the patient use effective contraception during treatment and for at least 6 weeks after the cessation of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
11. Is the patient of childbearing potential?	☐ Yes Proceed to question **12**	☐ No **Sign and date below**
12. Will the patient use effective contraception during treatment and for at least 6 weeks after the cessation of therapy?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **14**
14. Has it been confirmed that the patient is not pregnant by (-) HCG?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Will the patient breastfeed during treatment and for at least 2 weeks after the cessation of treatment?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

______________________________ Prescriber Signature

____________ Date

[03 January 2024]