US Family Health Plan

Prior Authorization Request Form for

Erdafitinib (Balversa)

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 an 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. Does the patient have locally advanced or metastatic urothelial carcinoma that has a susceptible FGFR3 mutation confirmed with an FDA-approved test?	☐ Yes Proceed to question **4**	☐ No Proceed to question **12**
4. Has the patient progressed during or following at least one line of prior systemic therapy?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Will the patient be evaluated by an ophthalmologist before starting treatment and every month for the first 4 months, and every 3 months thereafter?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Will the patient be advised to seek emergent evaluation for new ocular symptoms?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Will the patient be monitored for hyperphosphatemia? (*Note that 33% of patients required a phosphate binder in the trial supporting FDA approval for erdafitinib*)	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

8. Is the patient male or female?	☐ Male Proceed to question **11**	☐ Female Proceed to question **9**
9. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Is the patient breastfeeding?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **11**
11. Will patients with reproductive potential use highly effective contraception during treatment and for 1 month after the last dose?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
12. Please provide the diagnosis.	_____ Proceed to question **13**	
13. 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

[02 October 2024]