

USFHP 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

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Prior authorization does not expire. Clinical documentation may be required.

Step 1 Please complete patient and physician information (please print):

1	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?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Does the patient have locally advanced or metastatic urothelial carcinoma that has a susceptible FGFR3 mutation?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Proceed to question 5
4. Has the patient progressed during or following at least one line of prior systemic therapy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

USFHP Prior Authorization Request Form for
erdafitinib (**Balversa**)

5. The diagnosis IS NOT listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation.

To facilitate approval, please list the diagnosis, guideline version, and page number:

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

[08 January 2025]